THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

S. Jackson Kimball, Special Circuit Court Judge

Case No. 2011-CP-46-4508

Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to Owen C., a minor ..... Appellant

v.

Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, the York County Sheriff's Department, and York County Defendants

Of whom

Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center is the ..... Respondent.

RECORD ON APPEAL (VOLUME 2)

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provision of specialized services in multiple health care arenas such as palliative care, ethics, ambulatory care, rehabilitation, and geriatric services.

The *NASW Standards of Social Work Practice in Health Care Settings* are based on the consensus of expert health care social workers from across the country and are designed to enhance social workers' knowledge, skills, values, and methods necessary to work effectively with individuals, families (broadly defined), health care providers, and the community when practicing in health care settings.

Social Work Guiding Principles

The basic values of social work, from promoting an individual's right to self-determination to having an attitude of empathy for the individual, are the foundation of social work practice. When confronting dilemmas or needs in health care, social workers can use the principle of client self-determination in matters where clients or their proxies are faced with such issues (NASW, 2004).

Social workers have skills in cultural awareness and cultural competence, in which social work practice respectfully responds to, and affirms, the worth and dignity of people of all cultures, languages, classes, ethnic backgrounds, abilities, religions, sexual orientation, and other diverse features found in individuals (NASW, 2001). Social workers look at the person-in-environment, including all of the

factors that influence the total health care experience. Social workers practice at the macro and micro level of health care and thus have the ability to influence policy change and development at local, state, and federal levels and within systems of care. Social work research in health care benefits not only individuals and families, but also the very existence, effectiveness, and validation of the profession. These standards offer a guide for social workers practicing in any health care setting.

Definitions

Bioethics

Bioethics is the analysis and study of moral, legal, social, and ethical considerations involving the biological and medical sciences. Many health care settings have organized forums such as bioethics committees, institutional review boards, or consultation processes to address ethical dilemmas and questions.

Biopsychosocial–spiritual Perspective

The biopsychosocial–spiritual perspective recognizes that health care services must take into account the physical or medical aspects of ourselves (bio); the emotional or psychological aspects (psycho); the sociocultural, sociopolitical, and socioeconomic issues in our lives (social); and how people find meaning in their lives (spiritual). This approach draws from the strengths perspective of social work practice. The strengths perspective recognizes an individual's strengths and abilities to cope

with problems; and awareness and use of the client's strengths is part of the foundation of social work theory and practice. The strengths perspective is seen in social work practice through our role of enhancing personal strengths and resources, helping clients solve both interpersonal and environmental problems, and helping clients mobilize for change. The strengths perspective helps clients use their past successful choices and behaviors, skills, and insights to resolve or "work through" a current crisis (Tomaszewski, E. P., 2004; Saleebey, 2003).

Case Management

Case management, sometimes used interchangeably with care management, is the collaborative process of assessment, planning, and facilitation for options and services to meet an individual's complex needs. When appropriate, this would include arranging, coordinating, monitoring, evaluating, and advocating on behalf of the client and/or his or her family for the multiple services needed from a variety of social service and health care agencies. Case management addresses both the individual client's biopsychosocial-spiritual status (micro level) as well as the state of the social systems in which the services operate (macro level).

Client/Patient/Consumer

These terms refer to the person receiving care and treatment from physicians and allied health care personnel. Social workers generally use the term client to identify the individual, group, family, or community who seeks or is provided with professional services. The client is often seen as both the individual and the

client system or those in the client's environment. The term consumer is also used in settings that view the client as the consumer, that is, one capable of deciding what is best for her or himself and encourages self-advocacy and self-judgment in negotiating the social service and welfare system. The term *patient* is more commonly used by social workers employed in health care settings (Barker, 2003).

Continuum of Care

The care continuum includes the specialized health, social work services, rehabilitative, and home-based services that a seriously or chronically ill or injured person might need. This continuum addresses both the medical care and the other services that promote the patients' well-being (Barker, 2003).

Continuity of Care

Continuity of care ensures the coordination of care within an organization or across different agencies or settings to reduce duplicate services, to address gaps in existing services, and to ensure consistent and continuous services for the client as they transition in care or are discharged.

Disabling Condition

A disabling condition is considered a temporary or permanent reduction in a client's capacity or functioning based on the inability to perform some activities that most others can perform. A disabling condition can be congenital, can be the result of an accident or trauma, or more frequently is the result of chronic illness (that is, diabetes, hypertension).

Health Care Settings

Health care settings are practice areas in which assessment, care, and treatment address the physical, mental, emotional, and social well-being of the person; and address prevention, detection, and treatment of physical and mental disorders with the goal of enhancing the person's biopsychosocial and spiritual well-being. The health care setting includes personnel who provide the necessary services (for example, physicians, social workers, nurses, hospital attendants); appropriate service delivery facilities (for example, hospitals, hospice, assisted living, medical centers, and outpatient clinics); and educational and environmental facilities that work to help prevent disease (Barker, 2003).

Health Planning

Health planning is conducted in government organizations, medical and research organizations, and educational institutions and in prevention, early intervention, treatment, and follow-up. Planning should involve determining and ensuring the number of necessary health care personnel presently and in the future, and how to both finance and control costs. It includes where to locate facilities, how to provide the most effective means of service delivery, and how to provide services in a cost effective manner (Barker, 2003; NASW, 1987).

Managed Care

Managed care is a process designed to manage health care costs primarily through the private sector, although Medicaid's or Medicare's capitated systems are a form of managed care. It is a technique used by insurance carriers

and characterized by preauthorization to qualify the patient for particular services; preauthorization for a given amount of care; review of treatment and patient response(s); utilization review; predischarge planning to ensure the patient is ready to be released (having received the care required) and has an aftercare plan. Managed care plans include preferred provider organizations (PPOs), health maintenance organizations (HMOs), or a combined version through a point-of-service (POS) plan.

Medicaid

Medicaid is a government-funded health insurance program that provides payment for hospital, nursing home, home care, dental, and medical services to people who meet disability guidelines and income eligibility requirements. The Medicaid program is a shared federal/state/county program and although there are certain federal standards, states have a choice of benefits which they can choose to cover or not. Medicaid, administered by the Centers for Medicare and Medicaid Services (CMS), is the largest source of funding for medical and health-related services for people with a limited income (Centers for Medicare and Medicaid Services, 2004b).

Medicare

Medicare is a national health care program, administered by CMS, for most people age 65 and older, people with a variety of disabilities who are under age 65, and people with end-stage renal disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant (CMS, 2004a). Medicare is funded through a combination of

employer–employee contributions (as part of the person's Social Security), from earmarked taxes, and general federal revenues. Since Medicare is a federal program, benefits are the same in all 50 states.

Public Health Model

The Public Health Model of services focuses on the health of the individual, the family, and the larger community or general public and is administered by federal, state, and local agencies. The goal of programs, policies, and health care personnel is to prevent and treat disease, identify and eliminate environmental hazards, prolong life, and promote better health (Barker, 2003; NASW, 1987).

Standards for Social Work Practice in Health Care Settings

Standard 1. Ethics and Values

Social workers shall have knowledge of and practice according to the guidelines established by the NASW *Code of Ethics* (NASW, 1999).

Interpretation

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs of people who are vulnerable, disenfranchised, oppressed, and living in poverty. The mission is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence

In a health care system increasingly driven by technological advances, the ethical and moral questions and dilemmas raised for clients, families, and health care professionals are numerous and complex. Health care settings have designed a number of different systems to ensure ethical behavior among health care practitioners. Ethics committees are often used to provide "objective" reviews to health care providers and clients and families, when there is conflict between providers or providers, clients, and families. Institutional review boards are used to protect clients from the potential of experimentation in research projects. Social work supervision and peer consultation can also be used to discuss ethical issues facing practitioners.

Standard 2. Health Disparities

Social workers practicing in local, state, national, and international health care settings require knowledge and skills to help them recognize and address inequalities and injustices directed toward clients, organizations, and communities related to access to care and provision of health services.

Interpretation

Many social workers have historically delivered services as part of community-based organizations and public health programs to address health disparities among those who

are least likely to be able to gain access to adequate care. Social workers have an ethical obligation to address the health care needs of these groups and advocate for change to ensure access to care. Training of health care professionals to achieve a level of cultural competence—an understanding of practice patterns and attributes of diverse groups—is an essential part of basic and continuing education for all health care professionals, including social workers (Gilbert, 2003).

Health is a matter of both economics and social well-being. Both domestically and internationally, health care social workers strive to gain knowledge about health care: behavior, expenditures, reforms, systems, teams, insurance, health maintenance organizations, health protective behaviors, and more. Social workers also help clients to gain access to health care as they navigate between and among complex service delivery systems and entitlements.

Different entities shape public and global policies in every country. Therefore, social workers must keep abreast of policies to competently help clients and to assess physical, environmental, historical, situational, cultural, and structural factors that affect health care systems.

Accessibility to preventive, palliative, and curative health care depends largely on the client's ability to pay, and often, people cannot afford existing fees. In many nonprofit community-based clinics, services are provided on a "first come-first serve" basis (often with a long wait or long lines) and are limited by

a shortage of supplies and equipment. Increasingly, private systems of care emerge alongside public systems and other health care providers to care for the uninsured or underinsured who need health services, yet prefer to care for those who can pay fee-for-services. When these realities exist, social workers shall act as brokers, advocates, and mediators for clients.

Standard 3. Cultural Competence

Social workers shall develop and maintain an understanding of the history, traditions, values, and family systems of client groups as they relate to health care and decision-making. In compliance with the *NASW Standards for Cultural Competence in Social Work Practice* (NASW, 2001), social workers shall have a sensitivity to and awareness of the diversity in cultural groups and integrate this knowledge into their practice.

Interpretation

The importance of recognizing, respecting, and understanding other cultures and related health beliefs lays a foundation to build therapeutic alliances with clients and families. Social workers are responsible for self-reflection regarding the impact of their own cultural beliefs on their professional and personal life.

Social workers in health care shall approach each client and family interaction from a perspective of cultural respect and awareness. This implies reluctance to stereotype individuals based on assumed group similarities and seeks instead to ask individuals what aspects of their cultural experience are

meaningful in understanding a particular health care need. Social workers recognize that ethnic, cultural, spiritual, and religious factors can have an impact on health care choices and adherence to regimens of care.

Appreciation of cultural influences is especially important for clients at critical health junctures, such as birth, diagnosis of a major illness, and facing the end of life. Social workers have a responsibility to assist the client and family system in observing culturally meaningful practices whenever possible. When delivering culturally competent services, social workers should be guided by the *NASW Standards for Cultural Competence in Social Work Practice* (NASW, 2001).

Standard 4. Confidentiality

Health care social workers shall maintain appropriate safeguards for the privacy and confidentiality of client information.

Interpretation

Social workers must be familiar and comply with local, state, and federal mandates related to confidentiality. Professional judgment in the use of confidential information shall be based on best practice, ethical, and legal considerations (including the federal Health Insurance Portability and Accountability Act [HIPPA] regulations). Clients, families, and other professionals should be informed of the confidentiality limitations and requirements before services are initiated and in all phases of the health care experience.

Standard 5. Knowledge

Social workers in health care settings shall demonstrate a working knowledge of current theory and practice and integrate such information into practice.

Interpretation

The social worker uses knowledge about, and psychosocial implications of, illness, injury, and health conditions to provide social work services to clients and families to help them manage and cope with the impact of such health matters. Social workers have expertise in communication; navigating systems of care, resources, client and family coping skills; and the comprehensive impact of health conditions on the client. With the person-in-environment perspective, social workers look at all of the influences and aspects of a person's life to complete a thorough assessment and treatment plan with the client, family, and other health care professionals.

Essential areas of knowledge and understanding about health care include:

- the roles and functions of social work in health care
- the biopsychosocial needs of clients and families
- the physiological elements of illness and their impact on psychosocial functioning
- the psychological and spiritual needs of clients and families and how to ensure that they can be addressed
- community resources to assist clients and families
- the disparities across cultures and economic groups in gaining access to and funding for health care

- ethical and legal questions and dilemmas
- laws, regulations, and policies affecting clients, families, and social work practice
- the accreditation and regulatory standards governing settings providing health care
- evidence-based practices and social work research in health care
- the needs of special populations.

Standard 6. Assessment

Social workers shall provide ongoing assessment, including gathering comprehensive information to use in developing interventions and treatment strategies.

Interpretation

Assessment is a fundamental process of social work practice. Treatment and intervention strategies/plans require that social workers both assess and reassess client needs and modify plans accordingly. Social work assessments in health care settings include considering relevant biomedical, psychosocial, and spiritual factors and the needs of the individual client and the family (as defined by the client) (NASW, 2004).

A comprehensive, culturally competent assessment includes:

- past and current health status including genetic history of family health
- the impact of health conditions or treatments on cognitive, emotional, social, sexual, psychological, or physical functioning
- the impact on body image, intimacy, and sexuality

- social history, including current living arrangement and household environment
- work, school, or vocational history
- stage in the life cycle and related and relevant developmental issues
- cultural values and beliefs, including views on illness, disability, and death
- family structure and the client's role within the family
- social supports, including formal and informal support systems
- behavioral and mental health status and current level of functioning, including history, suicide risk, and coping styles
- financial resources, including access to and type of health insurance.

Comprehensive assessments shall address unique needs relevant to special populations, including children, people with severe and persistent mental illness, immigrants and refugees, people with substance use disorders, victims of violence or trauma, homeless people, and people with physical or psychiatric disabilities.

Standard 7. Intervention and Treatment Planning

Social workers implement intervention and treatment plans that promote client well-being and ensure a continuum of care. Planning shall be based on a comprehensive, culturally competent assessment with interdisciplinary input.

Interpretation

Intervention and treatment plans are steps identified by the health social worker, in collaboration with the client and with other

members of the team, to achieve objectives identified during assessment. Social workers shall be able to adapt practice techniques to best meet client needs within their health care setting to work effectively with individuals across the life-span, with different ethnicities, cultures, religions, socioeconomic and educational backgrounds, and across the range of mental health and disability conditions (NASW, 2004).

Intervention or treatment plans may include:

- strategies to address needs identified in the assessment
- information, referral, and education
- individual, family, or group counseling
- vocational, educational, and supportive counseling
- psychoeducational support groups
- financial counseling
- case management
- discharge planning
- interdisciplinary care planning and collaboration
- client and systems advocacy
- goals and objectives.

Standard 8. Case Management

Social work case management shall optimize client functioning. Case management facilitates collaboration among providers to address the client's biomedical and psychosocial needs to better provide efficient, appropriate, and beneficial health care services to a client with (often) multiple needs.

Interpretation

Social work case management requires the professional social worker to develop and maintain a therapeutic relationship with the client, which includes linking the client with resources that provide a range of services, resources, and opportunities to enhance successful quality outcomes for the client. Culturally competent case management is both micro and macro in nature and requires interdisciplinary care planning and collaboration with other professionals to maintain a team-oriented approach. Case management may include having regular meetings with the client and family and assisting the client to navigate systems.

The scope of services would include the following:

- psychosocial assessment, including diagnoses, interventions, and treatment plans
- financial assessment, planning, and intervention
- case facilitation
- patient and family counseling
- crisis intervention
- quality improvement
- resource brokering/referral/development
- continuity of care planning
- system integration
- outcome/practice evaluation
- teamwork/collaboration
- patient/family education
- patient/family advocacy

Standard 9. Empowerment and Advocacy

Social workers have a responsibility to advocate for the needs and interests of clients and client systems in health care, including advocating for larger system change to improve access to care and improved delivery of services.

Interpretation

Social workers have a special responsibility to advocate for the needs of the disenfranchised or the most vulnerable of the population at both the micro and macro levels. Social workers will identify barriers to services and actively seek to resolve them. The responsibility to advocate for quality improvement also implies a responsibility for health social workers to act as advocates to expand the role of the profession, develop leadership programs, and mentor new professionals.

Standard 10. Client and Community Education

Social workers act as educators for clients, families, the community, and other professionals regarding disease prevention, impact of illness and disease progression, advocacy for benefits, health maintenance, and adherence to treatment regimens.

Interpretation

Social workers have a formal role as educators. Social workers gain knowledge and expertise in the health practice setting from other professionals and from formal education, work, or teaching experience. They have the knowledge and skill to implement the principles of learning theories in education programs, activities, and resources. They

communicate and collaborate with departments and other staff to foster client education. They serve with other members of the health care team for program and resource development, planning, implementation, and evaluation.

Social workers use a variety of methods to define and identify learning needs of individuals and families. Assessment identifies the educational needs based on the expressed needs of individuals, family members, and significant others. The social worker identifies deficiencies in the knowledge base of the client and works with the client to obtain the needed information and resources. Social workers collaborate with the health care team to design educational activities to meet the client's needs, to deliver the activities in a method that facilitates the learning needed, and to evaluate the process in an integral, ongoing, and systematic manner.

Standard 11. Teamwork and Collaboration

Social workers shall participate in care teams, and collaborate with other professionals, volunteers, and groups in and outside of their practice setting to enhance all aspects of the client and family system's care.

Interpretation

Social workers participate in multiple care teams, which are typically interdisciplinary. These teams often provide comprehensive care and information in a client's home, in outpatient or inpatient health, and mental health care settings.

As part of such teams and collaborations, social workers shall demonstrate the ability to:

- understand the mission and functions of the service organization or group for which the social worker is employed
- understand the role of other relevant professions and organizations
- communicate and cooperate appropriately with other disciplines and agencies
- ensure that the social work role and responsibilities are clearly delineated and communicated to other members of the team
- ensure that the roles and responsibilities of each collaborating organization are clearly delineated and communicated
- advocate for changes in care that reflect the interests of the client and client system
- communicate the client's information in a respectful and objective manner and protect the client's confidentiality and privacy
- share leadership and decision-making functions

Standard 12. Workload

Health care social workers shall maintain a workload that allows for efficient and quality social work service delivery. The size of the social work staff shall represent the scope and the complexity of the organization and the nature and numbers of the populations served.

Interpretation

Both the health care organization or setting and the social work leader and staff have joint responsibility for establishing and maintaining a workload that allows for adequate and appropriate interventions and monitoring of

services and outcomes. A workload consists of any social work function performed for the purpose of the social work position, including direct practice, administration, policy, research, or education. The workload also reflects the demands of the population served and may include social work coverage outside of regular office hours. It is the joint responsibility of the organization and the social worker to resolve issues of workload concerns.

Standard 13. Documentation

Social workers shall maintain records or documentation of social work services, which reflect the client and client systems' pertinent information for assessment and treatment; social work involvement and outcomes with and for clients; and in accordance with care goals and legislative and administrative regulations and policies.

Interpretation

The importance of clear, concise, and organized documentation reflects the hallmark of quality social work services and often serves as the mode of communication between a social worker and other professionals and clients. There are core elements that need to be included and responsibilities to follow in record keeping. The elements and responsibilities of thorough and comprehensive documentation include the following:

- comprehensive assessment and services delivered to the client and client systems, including the development of a plan of care

- ongoing assessments, interventions, and treatment planning
- goals and planning that reflect an explicit statement of agreement with client, client systems, and team input
- referral sources and collaborations
- dates, times, and descriptions of client and client system contacts
- documentation of outcomes
- reason for case closure or transfer
- written permission to release and obtain information, where appropriate
- documentation of compliance with confidentiality rights and responsibilities
- documentation of receipts and disbursements

Standard 14. Research

Health care social workers shall understand research planning, methodology, evidence-based outcomes, and program evaluation.

Interpretation

Social workers have a responsibility to be familiar with the literature crucial to their area of practice. As professionals, social workers in all settings have a mandate to improve the knowledge of the field, and this can best be accomplished through participation in research activities.

Venues where health care social workers might help to develop, implement, or evaluate research include inpatient and outpatient hospital-based settings, community or home health agencies, and federally funded clinical trial research networks. Rich data sources that permit opportunities for quantitative and qualitative research exist within these entities.

Clinical trials (methodological assessments of the safety and efficacy of new treatments or new methods for administering existing treatments) help answer scientific questions and greatly depend on study participants' committed participation. Social workers may help physicians, nurses, pharmacists, and others recruit individuals and encourage study participation and adherence to medication regimens; they can also help clients manage problems that may hinder adherence and retention, such as challenging life circumstances and demands from family members.

Standard 15. Performance Improvement

Health care social workers shall be a part of ongoing, formal evaluation of their practice to assess quality and appropriateness of services, to improve practice, and to ensure competence.

Interpretation

Social workers are trained to facilitate improvements that alter the processes in which health care is delivered. They are ethically charged to promote process improvements that will enhance patient or consumer safety, satisfaction, efficient and effective care, and identify and promote best practices and equitable care on a multidisciplinary basis.

The evaluation of social work practice is a vital part of social work service delivery. The methods to evaluate such practice include peer review, self-evaluation, supervision, and other research methods. Increasingly, social work outcomes from evaluations are used for position justification, performance review,

social work standards for practice, goal setting, and research efforts. Evaluation practices may include the following:

- using appropriate tools such as clinical indicators, practice guidelines, consumer satisfaction surveys and measures, and standardized performance assessments
- assessing both outcome and process objectives
- involving the client and client system and colleagues in the evaluation process
- protecting the privacy of the client and client system and other professionals
- disseminating evaluative data to clients, payers, and other professionals on request and adhering to privacy rights
- using external practice evaluators as appropriate
- participating in social work research.

Standard 16. Access to Information and Technology

Health care social workers shall have access to computer technology and the Internet, as the need to communicate electronically and to seek information on the Web for purposes of education, networking, and resources is essential for efficient and productive practice.

Interpretation

Health care professionals, including social workers, communicate, learn, educate, and document using computer technology on a daily basis. Social workers need initial and ongoing training in technology applications relevant to their practice, including clinical care, research, policy, education, resource finding, and administration. Social workers

shall continue to follow guidelines for privacy with regard to confidential information of the client, family, or health care providers.

Standards for Professional Development, Education, and Leadership

Standard 17. Qualifications

Health care social workers shall meet the provisions set for practice by NASW.
A sufficient number of qualified social work personnel shall be on staff to plan, provide, and evaluate social work services.

Interpretation

Health care social workers shall have a social work degree from a school accredited by the Council on Social Work Education (CSWE). As a distinct specialty within the social work profession, health care social work requires specialized knowledge as outlined in these Standards. The social worker should receive this knowledge and skill set from involvement or internship in a health care setting, preferably under social work supervision.

Social workers functioning in leadership roles, such as managers or directors, should be licensed at the advanced practice level and able to provide supervision for licensure. Their experience shall show evidence of advanced practice skills and judgment demonstrating progressively more professional competence and supervisory and management skills.

Standard 18. Continuing Education

Health care social workers shall assume responsibility for their own continued

professional development in accordance with the *NASW Standards for Continuing Professional Education* (NASW, 2002) and state requirements.

Interpretation

Social workers shall remain knowledgeable about medical diagnoses and advancements, and the psychosocial implications of illness, injury, disability, and treatment. To accomplish this goal, social workers shall continually seek to improve their practice through education and training, and to share this knowledge with other colleagues. Opportunities for professional education are available through health care organizations; NASW Web courses and chapters; participation and contribution to professional conferences, training events, and other activities; ongoing psychosocial research; current practice models; and professional publications.

Social workers shall assist in identifying health care and psychosocial topics for professional development by participating in research; by encouraging organizations and institutions to collaborate, advocate, and provide appropriate education for the field; and from clinical practice.

Standard 19. Supervision

A social work leader or supervisor shall be available to supervise health care social work staff on their responsibilities in practice, research, policy, orientation, and education.

Interpretation

The purpose of supervision is to enhance the clinical social worker's professional skills and

knowledge, to enhance competence in providing quality patient care. Supervision aids in professional growth and development and improves clinical outcomes. Experienced social workers shall offer guidance and consultation to students, interns, and less experienced peers. Consultation and guidance are separate from supervision, and may be offered in mentoring opportunities.

Standard 20. Leadership

Social workers across all health care settings have a responsibility to provide leadership to ensure access to care and to improve and maintain the quality of care provided by an agency or institution. Leadership skills can be demonstrated in teams and groups across health care settings, and include mentoring others within and outside the social work profession.

Interpretation

Social work leaders typically demonstrate knowledge, skills, and abilities in the following areas:

- management/administration, which includes supervision, consultation, negotiation and monitoring
- specialized knowledge of how to function within care teams in which various disciplines are involved
- research and education
- legal, ethical, and professional standards applicable to health social work practice including standards of documentation (paper and computer) and quality improvement activities

- ability to prioritize needs for social work services and to recommend adjustments to staffing levels accordingly based on current literature and industry standards
- social work qualifications, productivity, and continuing education
- policies and regulations that affect social work practice, and patient and family care
- information on access to health care for the underserved and marginalized populations
- consultation to social workers and allied health professionals on relative health social work practice issues
- development of and adherence to organizational policies, procedures, and regulations by staff.

Free information on the Standards is located on the NASW Web site: www.socialworkers.org.

Purchase full document from NASW Press at 1.800.227.3590.

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EXHIBIT

"5"

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital

Contents

Introduction

EXHIBIT 5

Monitoring the quality and appropriateness of psychosocial and social work services in acute care medical hospitals is an area of increasing concern to the health care field. Social workers and their supervisors desire specific measures of service delivery and patient care outcome to monitor quality and to position the profession strategically as the health care system evolves. Institutions and insurers call for quality services to avoid expensive delays in discharge and to prevent the need for readmissions. Accrediting organizations seek consistency in data collection, analysis, and comparison across institutions.

In response to these concerns, the National Association of Social Workers' Commission on Health and Mental Health, in conjunction with the Society of Hospital Social Work Directors of the American Hospital Association, has established clinical indicators to be used in the systematic monitoring of the quality and appropriateness of patient care. Indicator development is an ongoing process that encompasses testing, improvement, and innovation. These indicators serve as broad guidelines to allow for the varied needs of diverse institutions while encouraging more uniformity in social work quality assurance.

Clinical indicators are not intended as direct measures of the quality of clinical performance. They are best thought of as "flags" that, at a predetermined threshold, "go up" and signal the need for problem analysis or peer review.

The following information is provided for each indicator:

1. Rationale: an explanation of the logical connection between the "flag," social work functions, and an important dimension of quality
2. Operational definition: a definition of the indicator that allows for reliable measurement across practice settings
3. Threshold: the predetermined point at which the "flaggoes up," precipitating closer scrutiny and evaluation
4. Data elements: the specific information needed to measure the indicator
5. Other influencing factors: factors beyond the control of the individual practitioner that influence the provision of care

Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital were developed by a panel of recognized expert practitioners from a variety of related settings and facilities and reviewed by practitioners in the field. NASW's Commission on Health and Mental Health and the Board of Directors of the Society of Hospital Social Work Directors formally accepted the indicators in June 1990.

Scope of Practice for Social Work and Psychosocial Services

Mission

Social work services are provided to patients and their families to meet their medically related social and emotional needs as they impinge on their medical condition, treatment, recovery, and safe transition from one care environment to another.

Patients Served

Depending on individual circumstances and need, social work services are available to all patients and their families. Groups at high psychosocial risk include frail elderly patients, chronically ill people, children and adults with handicapping conditions, victims of maltreatment, and critically ill patients. Social workers serve patients who are insured, uninsured, and underinsured.

Major Functions and Services Provided

- Psychosocial assessment
- High social risk case finding and screening
- Information and referral Preadmission planning
- Discharge planning Psychosocial counseling
- Financial counseling
- Health education
- Postdischarge follow-up
- Consultation
- Outpatient continuity of care
- Patient and family conferences
- Case management
- Self-help and emotional support groups for patients and families
- Patient and family advocacy

Major Categories of Problems Addressed

- Problems related to care and activities of daily living
- Environmental problems
- Patient and family adverse reactions or dysfunctional adjustment to illness and changes in functional status
- Problems related to physical, sexual, and emotional maltreatment
- Relationship problems
- Problems of behavior and cognition and mental disorders, including substance abuse
- Vocational and educational problems
- Legal problems

Providers

Social work services are performed by qualified social workers and others under the supervision or direction of the social work department.

Recommended Core Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital

Appropriateness of Care Indicators

Indicator 1

Important aspect of care. Case finding.

Rationale. Patients who need social work intervention must receive it for overall care to be considered appropriate. The percentage of inpatients needing social work in a hospital should remain similar over time unless there is a change in case mix, scope of services, or the surrounding environment. Thus, major shifts in the percentage of discharges receiving social work services may be a sign that the case finding mechanisms are not proper and that care may not be appropriate.

Operational definition. Rate of social work discharges to total discharges.

Threshold. Needs empirical determination.

Data elements. The number of cases discharged from the hospital by social work in one month divided by the total number of cases discharged by the hospital in that month.

Other influencing factors. Scope of service, case mix (social complexity), hospital type.

Indicator 2

Important aspect of care. Discharge planning.

Rationale. One aspect of appropriateness is that the amount of care received is not excessive. Excessive care results when discharge is delayed and patients remain at higher levels of care than are medically necessary.

Operational definition. The percentage of patients designated as below acute level of care by utilization review (UR).

Threshold. Needs empirical determination.

Data elements. Number of patients staying beyond UR acute level of care divided by the number of discharges in one month.

Other influencing factors. Patient recertified.

Quality of Care Indicators (Process)

Indicator 3

Important aspect of care. Discharge planning.

Rationale. The standard of practice is that social workers must involve patients and their families in making their own decisions about posthospital care. Involvement must include, at a minimum, discussion of patient and family preferences.

Operational definition. Patient and family preferences are recorded in the social work discharge plan.

Threshold. 95 percent.

Data elements. The number of cases with patient and family preferences recorded in social work discharge plan divided by the number of social work discharges with social work discharge plan.

Other influencing factors. Incompetent patient, no family members available.

Indicator 4

Important aspect of care. All.

Rationale. Patients and families need sufficient time to make decisions and adapt to illness, and shortened lengths of hospital stay limit the availability of time. Therefore, the standard of practice is that most patients in need of social work services must receive their initial service early in their hospital stay.

Operational definition. The percentage of patients receiving their first social work service in the first quartile of their length of stay (in most cases, in the first 48 hours).

Threshold. Needs empirical determination.

Data elements. Date of admission, date of discharge, date of first social work contact after admission.

Other influencing factors. Patient stay is less than three days.

Indicator 5

Important aspect of care. Coordination of discharge planning.

Rationale. Social workers are responsible for coordination of patients' discharge plans, especially when posthospital care is required. When discharge of a patient receiving social work services occurs without the social worker's knowledge, this may indicate poor quality of the coordination process.

Operational definition. Social work patients discharged without social worker's knowledge.

Threshold. 0 percent.

Data elements. Number of social work patients discharged without social worker's knowledge divided by the number of social work discharges.

Other influencing factors. Service is information and referral only, consultation only, or psychosocial assessment only.

Quality of Care Indicator (Outcome)

Indicator 6

Important aspect of care. All.

Rationale. Social workers are responsible for ensuring that patients receive the immediate posthospital care they need and adapt to the posthospital setting. Readmission of too many patients due to social complications suggests either that they did not receive social work services or that these services were inadequate.

Operational definition. Percentage of discharges readmitted within 15 days with social complications or problems with posthospital care.

Threshold. Needs empirical determination.

Data elements. Number of patients readmitted with social complications divided by the number of hospital discharges.

Other influencing factors. Complications occurring after the primary discharge, case mix.

Recommended Additional Indicators

These indicators are highly desirable for use and provide direction for future quality assurance efforts. It is recognized that barriers in some hospitals may preclude their immediate implementation.

Quality of Care Indicator (Process)

Indicator 1

Important aspect of care. Discharge planning and follow-up.

Rationale. Patients who are at high risk for developing problems with postdischarge care should receive a follow-up assessment after discharge to determine whether the aftercare plan is being implemented as planned.

Operational definition. Percentage of discharged patients who received social work discharge planning who receive postdischarge follow-up within seven days.

Threshold. 95 percent.

Data elements. Number of discharged patients receiving social work postdischarge follow-up within seven days divided by the number of discharged patients receiving social work discharge planning.

Other influencing factors. Patient dies, case mix (social complexity).

Quality of Care Indicator (Outcome)

Indicator 2

Important aspect of care. All.

Rationale. The intent of social work intervention is to improve or resolve patients' psychosocial problems related to their medical care. Problem improvement or resolution is an indicator of whether the intervention has achieved its goal.

Operational definition. Percentage of planned results not achieved specific to each problem.

Threshold. Needs empirical determination.

Data elements. Number of social work patients discharged from hospital in one month having problem X with "not resolved" as outcome divided by the number of social work patients discharged from hospital in that month having problem X. This indicator requires a well-defined problem list and reliable categories for problem resolution.

Other influencing factors. Patient dies, case mix (social complexity).

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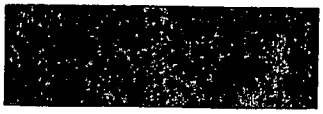

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EXHIBIT

"6"

CAROLINAS HEALTHCARE SYSTEM

Category: Patient Rights
Policy: Abuse
Number: PR 110.03
Date of Issue: 08/91 Reviewed / Revised: 05/11

JUVENILES SUSPECTED OF BEING ABUSED OR NEGLECTED

SUMMARY STATEMENT

This policy statement relates to the issue of awareness, detections and management of children at risk for abuse or neglect in the inpatient, physician office, and urgent care settings. It provides guidance on the procedure that should be followed in cases of suspected abuse or neglect.

DEFINITIONS

A. **Juvenile**

Any person under 18 years of age who is not emancipated by marriage or court order, or a member of the armed forces.

B. **Abused Juvenile**

1. A juvenile whose parent, guardian, custodian or caretaker

a. inflicts or allows to be inflicted serious physical injury, which causes or creates a substantial risk of injury, death, disfigurement, impairment of physical health or loss or impairment of a function of any bodily organ;

b. uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior;

c. creates or allows serious emotional damage;

d. commits or permits illegal sexual activity with or by the juvenile; or

e. encourages or approves the juvenile's commission of delinquent acts.

C. **Neglected Juvenile**

1. A juvenile who:

a. is receiving improper care, supervision, or discipline;

b. has been abandoned; (See abandoned infant/child policy)

c. is not provided necessary medical or remedial care;

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EXHIBIT 6

d. lives in an injurious environment or has been placed illegally in care or for adoption.

2. A special needs infant who:

   a. is being denied appropriate nutrition, hydration, or medication; or

   b. has medically indicated treatment withheld unless, in the treating physician's judgement, one of several conditions is met.

It is relevant to consider whether the juvenile lives in a home where another juvenile has died as a result of abuse or neglect or in a home where another juvenile has been subjected to physical abuse by an adult who regularly lives in the home.

D. **Dependent Juvenile**

1. A juvenile who:

   a. is in need of assistance or placement because there is no parent, guardian or custodian responsible for the juvenile's care or supervision; or

   b. has a parent, guardian, or custodian, due to physical or mental incapacity and in the absence of an appropriate alternative child care arrangement, who is unable to provide for care or supervision.

E. **Caretaker**

1. Any person other than a parent, guardian or custodian, or adult member of the juvenile's home, who has care of a juvenile, including any blood relative, stepparent, foster parent, or house parent, cottage parent, or other person supervising a juvenile in a residential child care facility; or

2. Any adult person with the approval of the care provider in a day care facility.

PROCEDURE

A.

1. Clinical team identifies child in whom abuse or neglect is suspected and initiates suspected child maltreatment inpatient order set followed by discharge order set if applicable.

2. Consult CHS Clinical Care Management Social Worker to aid in the assessment process.

   CPN/Urgent Cares: page 704-355-4088 pager 1436.

   CHS Hospitals: utilize your hospital MSWs during regular business hours (8:00am - 4:30pm) and page 704-355-4088 pager 1436 for after hour concerns. Refer to NC Statute 90-21.20 (b) for indications for law enforcement involvement (Attachment A).

3. Complete CHS Suspected Child Abuse and Neglect (SCAN) form available on Care

Line. Use SCAN admission and discharge order forms for admission to LCH.

4. Document all positive exam findings on SCAN form including completion of diagrams. If evidentiary photography is requested by outside agency they are responsible for securing such photography and maintaining chain of custody. Contact SCAN on call team or Child Maltreatment Coordinator for assistance with photography documentation needed for child's medical management.

5. All cases of suspected abuse or neglect should be reported to the Department of Social Services (DSS) in the County where the child resides. The call to DSS may be initiated by the staff member identifying the abuse/neglect, the medical social worker or any other member of the healthcare team involved in the case. Have readily available as much of the following information as possible:

   - the facts of the case
   - the child's and parents' home address, telephone numbers, dates of birth and social security numbers
   - siblings names, ages and whereabouts

6. If the parent, guardian, custodian or caretaker refuses to authorize necessary medical treatment for the juvenile, refer to administrative policy *PR 120.06 Consent for Treatment.*

7. Consider consult to CMC Pediatrics (CHIPS Team; Children's Hospital Inpatient Service) for assistance with medical management. For patients with evidence of acute, multi-system injury consult CMC Trauma Service.

8. Refer to Child Maltreatment Clinical Practice Guidelines to assist with medical management. (Attachment B, B1-3)

9. **When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS and the safety plan has been placed on the chart in writing, if applicable.**

B. When a physician determines that a juvenile should remain in the hospital for medical reasons, or that it is unsafe for the juvenile to return to his or her parent, guardian, or caretaker, the physician or administrator should first contact the director of the Department of Social Services (or representative on call) to determine if the Department of Social Services will take emergency custody and authorize the hospital to retain physical custody of the juvenile.

   In the event the Department of Social Services is unwilling to take custody or cannot be contacted, the local District Court has authorized the physician or administrator to retain physical custody of the juvenile whenever the physician determines that (1) the juvenile should remain for medical treatment or (2) according to his or her medical evaluation, it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker. (See *Administrative Order, Attachment C)*

To retain physical custody under court order, the physician who examines the juvenile must certify the applicable circumstances in writing on the *Certification of Necessity for Retention of Custody, Attachment D.* A copy of the written certification must be provided to the juvenile's parent, guardian, custodian, or caretaker and the director of the Department of Social Services. A copy of the completed certification must be placed in the juvenile's medical record.

The Administrative Order allows the hospital to keep physical custody of the juvenile for a period not to exceed twelve hours from the time and date of the written certification. Before the twelve hours expire, either the Department of Social Services must have assumed custody or the Juvenile Court must issue an additional order permitting continued custody beyond twelve hours.

C. Any person making a report of suspected juvenile abuse, neglect, or dependency, or who testifies in a later court proceeding resulting from a report, is immune from civil or criminal liability so long as the person acted in good faith.

D. If it is suspected the juvenile has been the victim of a crime but does not come under the definition of "abused juvenile" or "neglected juvenile", the juvenile's parent, guardian, custodian, or caretaker and/or law enforcement officials should be notified. **If a juvenile seeks treatment for a sexually related assault then reporting is based on the juvenile's consent (NC Statue 90-21.5).** See (Attachment E).

E. Any questions concerning this procedure should be directed to the facility administrator or the Carolinas HealthCare System office of Risk Management.

REFERENCES

See Attachment A: Involvement of Law Enforcement (NC Statute 90-21.20 (b)).
See Attachment B: Child Maltreatment Clinical Practice Guidelines
See Attachment C: Administrative Order Retention of Custody of Juvenile Suspected to be Abused
See Attachment D: Certification of Necessity for Retention of Custody
See Attachment E: Situations in which minors may consent to treatment (NC Statute 90-21.5)
See Attachment F: Child Abuse and Neglect Algorithm

APPROVALS

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Attachment A
INVOLVEMENT OF LAW ENFORCEMENT

Article 1C

Physicians and Hospital Reports

§90-21.20. Reporting by physicians and hospitals of wounds, injuries and illnesses.

(a) Such cases of wounds, injuries or illnesses as are enumerated in subsection shall be reported as soon as it becomes practicable before, during or after completion of treatment of a person suffering such wounds, injuries, or illnesses. If such case is treated in a hospital, sanitarium or other medical institution or facility, such report shall be made by the Director, Administrator, or other person designated by the director or Administrator, or if such case is treated elsewhere, such report shall be made by the physician or surgeon treating the case, to the chief of police or the police authorities of the city or town of this State in which the hospital or other institution, or place of treatment is located. If such hospital or other institution or place of treatment is located outside the corporate limits of a city or town, then the report shall be made by the proper person in the manner set forth above the sheriff of the respective county or to the one of his deputies.

(b) Cases of wounds, injuries or illnesses which shall be reported by physicians, and hospitals include every case of a bullet wound, gunshot wound, powder burn or any other injury arising from or caused by, or appearing to arise from or be caused by, the discharge of a gun or firearm, every case of illness apparently caused by poisoning, every case of a wound or injury caused, or apparently caused, by a knife or sharp or pointed instrument if it appears to the physician or surgeon treating the case that a criminal act was involved, and every case of a wound, injury or illness in which there is grave bodily harm or grave illness if it appears to the physician or surgeon treating the case that the wound, injury, or illness resulted from a criminal act of violence.

(c) Each report made pursuant to subsections (a) and (b) above shall state the name of the wounded, ill or injured person, if known, and the age, sex, race, residence or present location, if known, and the character and extent of his injuries.

(c1) In addition to the reporting requirements of subsection (b) of this section, cases involving recurrent illness or serious physical injury to any child under the age of 18 years where the illness or injury appears, in the physician's professional judgment, to be the result of non-accidental trauma shall be reported by the physician as soon as it becomes practicable before, during, or after completion of treatment. If the case is treated in a hospital, sanitarium, or other medical institution or facility, the report shall be made by the Director, Administrator, or other person designated by the Director or Administrator of the medical institution or facility, or if the case is treated elsewhere, the report shall be made by the physician or surgeon treating the case to the chief of police or the police authorities of the city or town in this State in which the hospital or other institution or place of treatment is located. If the hospital

or other institution or place of treatment is located outside the corporate limits of a city or town, then the report shall be made by the proper person in the manner set forth above to the sheriff of the respective county or to one of the sheriff's deputies. This reporting requirement is in addition to the duty set forth in G.S. 7B-301 to report child abuse, neglect, dependence, or the death of any juvenile as the result of maltreatment to the director of the department of social services in the county where the juvenile resides or is found.

(d) Any hospital, sanitarium, or other like institution or Director, Administrator, or other designated person, or physician or surgeon participating in good faith in the making of a report pursuant to this section shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed as the result of the making of such report. (1971, c.4; 1977, c. 31; c. 843, s.2.)

Attachment B
CHILD MALTREATMENT CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines
CHS Inpatient Units and Emergency Department

Evaluation and Management of Suspected Child Abuse or Neglect

I. CHILD PHYSICAL ABUSE

A. Identification

Injuries (bruises, burns, fractures; this list is not inclusive) that should be considered suspicious for physical abuse:

1. Age 0-6 months: Any injury.

2. Age 6 months or older:

   a. Bruises, lacerations, or burns to protected, fleshy, or flexor surfaces— for example, inner thighs, abdomen, neck, face (other than frontal prominence), pinna, and genitalia.
   b. Bruises, lacerations, or burns showing an object pattern—for example, belt loop, cigarette burn, and curling iron.
   c. Full thickness burns, especially scald burns.
   d. Fractures, especially metaphyseal fractures, complex or wide skull fractures, rib fractures, sternal fractures, spinous process fractures or scapula fractures.
   e. Significant head injury, especially subdural hematoma, retinal hemorrhage, subgaleal hematoma, avulsed hair, complex or wide skull fracture. Head injury should be considered whenever a child presents with vomiting or altered consciousness, or bloody spinal fluid is found on lumbar puncture, but an infectious process cannot be readily diagnosed.
   f. Intraabdominal injury, especially rupture or hematoma of internal organ.

3. Age 0-10 years (or older based on clinical evaluation): Positive urine or blood screen for alcohol or drugs of abuse. Injuries that are not consistent with history.

B. Essential Aspects - Caretaker History

1. Does the parent/guardian or child give a logical explanation that is consistent with the age, pattern, and severity of the injury? This should be assessed by clinician familiar with normal pediatric development.

   a. Consider developmental level of child. Is the child capable of the reported action? For example—a 6-month-old cannot unbuckle a car seat.

b. Consider biomechanics of injury. For example--a fall from less than 4 feet rarely causes a fracture and almost never causes intracranial hemorrhage; a child who cannot crawl or walk should not have a bruise, fracture, burn, or laceration.

C. Evaluation & Treatment

1. Refer to CHS policy *PR 110.03* for policies regarding reporting of *Juveniles Suspected of Being Abused or Neglected.*

2. Complete physical examination

3. Complete SCAN form (available on Care Line) and SCAN Admission Order Set.

4. Age 0-2 years: Non-accidental Trauma (NAT) series should be considered in all cases (not long bone series or "babygram"). **Pediatric radiologist to do official reading.**

5. Age 2-4 years: NAT series should be considered (not long bone series or "babygram"). **Pediatric radiologist to do official reading.**

6. Nuclear medicine bone scan (or repeat NAT series in 2 weeks) if index of suspicion for skeletal injury remains high despite negative initial NAT series (for example-- in cases of Abusive Head Trauma (formerly known as "Shaken Baby Syndrome").

7. A screening panel to rule-out bleeding disorder should be considered (refer to SCAN Admission Order set).
   a. CBC with platelets & peripheral smear
   b. PT/PTT
   c. PFA-100 (platelet function assay)
   d. Fibrinogen
   e. Thrombin time

8. Liver enzymes (AST/ALT), amylase, and lipase levels should be considered if abdominal trauma is suspected or present.

9. CT scan of head if suspected acute intracranial injury or other injuries that indicate need to assess for non-accidental injuries; consider MRI scan of head if subacute (older than 5 to 7 days) or chronic intracranial injury after 2-3 days and patient is stable.

10. CT scan of abdomen if suspected blunt thoracoabdominal trauma or abdominal bruising present.

11. Pediatric Ophthalmology consult for thorough fundoscopy in cases of:
    a. Suspected intracranial injury;
    b. Suspected Abusive Head Trauma (metaphyseal fractures, subdural/subarachnoid

hemorrhage, and/or posterior rib fractures).

c. Spiral fracture, metaphyseal fracture, or other injury in child under age 2 suggestive of shaking or twisting injury.
d. Fracture in infant under age 6 months or any other highly specific fracture for abuse under 1 year.

II. CHILD SEXUAL ABUSE

A. Identification

Findings that should be considered suspicious for sexual abuse (this list is not inclusive):

1. Any injury to the genitalia (especially to the hymen or vestibule in girls) or anus.
2. Identification of an STD: Chlamydia, gonorrhea, HSV, HPV, HIV, HBV, HCV, Trichomonas, syphilis.
3. Positive pregnancy test (especially if < 14 y/o).
4. Any history or statement or witnessed incident consistent with sexual abuse.

B. Essential Aspects - Caretaker History

1. Does the parent/guardian or child give a logical explanation that is consistent with the examination findings? For example--in a child under 3 with genital warts, is there a history of maternal HPV infection during pregnancy or delivery?

C. Evaluation & Treatment

1. Refer to CHS policy *PR 110.03 Juveniles Suspected of Being Abused or Neglected* for policies regarding reporting.
2. Complete physical examination
3. Use SCAN form for documentation.
4. Age 0-2 years: skeletal survey in all cases with visible acute injuries.
5. Age 2-4 years: skeletal survey should be considered if visible acute injuries.
6. For non-acute sexual abuse allegations in an otherwise healthy child without continued access to an alleged perpetrator: after reporting to the appropriate investigating agencies, a child may be referred to their primary care provider or Pat's Place Child Advocacy Center in lieu of receiving a detailed sexual abuse examination in the Emergency Department.
7. Careful inspection of external genitalia and anus for evidence of trauma, in exam

setting with adequate lighting, positioning, and magnification. Never force a child to be examined.

a. Position child in a supine frog-leg position; adolescent male in supine position for genitalia and decubitus position for anus exam; adolescent female supine in heelrests (dorsal lithotomy).
b. In girls, use gentle labial traction technique to visualize vestibule and hymen. Also inspect labia majora, perineum, inner thighs, and lower abdomen.
c. In girls, position in the prone knee-chest position to confirm suspected abnormal hymenal or vestibular findings.
d. In boys, careful inspection of penis, scrotum, perineum, inner thighs, lower abdomen.
e. In both sexes, careful inspection of anus and perianal area for evidence of trauma. Use gentle gluteal separation to inspect anal rugae and outer canal.

8. Testing for sexually transmitted infection may be obtained if the history suggests the child had genital/anal/oral contact with the perpetrator's genitalia, there is evidence of genital/anal/oral trauma, or if there is genital/anal discharge:

- Gonorrhea cultures (Thayer Martin media, NOT DNA PROBES) of: throat; vagina (in prepubertal or young teen girls), cervix (in postpubertal girls), or male urethra, and anus.
- May consider use of urine PCR (urine NAAT) testing for Gonorrhea or Chlamydia, but is not considered legal gold standard. Positive urine PCR should be confirmed with culture. Obtain culture if giving prophylaxis in prepubertal patients
- Chlamydia cultures (pink viral culture media, NOT DNA PROBES) of: vagina (in prepubertal or young teen girls), cervix (in postpubertal girls) or male urethra, and anus.
  Note: to cause minimal discomfort while culturing the vagina in prepubertal girls, the examiner should use labial traction technique to identify the hymenal introitus. An assistant should gently insert a mini-tip (urethral-size) Dacron swab moistened with nonbacteriostatic saline or water through the introitus without contacting the hymen, and gently swab the distal vagina.
- Blood should be drawn for syphilis and HIV. Evaluate the patient's hepatitis B immunization status.
- Wet prep of discharge for trichomonas, clue cells, or leukorrhea (>10WBC/HPF).
- Culture of vesicles or ulcers for HSV.
- HIV and RPR should be obtained if indicated by history.

9. If acute sexual assault (penetrating genital injury and/or contact with perpetrator's genitalia within the past 72 hours):

a. A forensic evidence collection kit (SBI rape kit) should be utilized. Contact the relevant law enforcement agency for retrieval of evidence and maintain appropriate chain of custody.

b. Cultures and blood for STD's should generally not be obtained unless there is an additional clinical indication (prior abuse or symptoms).
c. DNA probes may be obtained (see above) as screening. However cultures remain the gold standard.
d. Prophylactic antibiotic therapy against gonorrhea and chlamydia infection should be given if requested by patient or family in case of child sexual assault. Consider prophylaxis against trichinosis and pregnancy. Prophylactic therapy should be administered in cases of adolescent sexual assault. Refer to Centers for Disease Control or American Academy of Pediatrics guidelines for current recommendations. See Attachment # B-1.
e. Prophylactic antiretroviral therapy should be offered to the victim and/or family whenever contact with potentially infectious bodily fluids may have occurred, and must be offered if the alleged perpetrator is known to be at high risk for HIV infection. If the perpetrator is unknown, the decision for therapy should be based on the local HIV epidemiological rate. Consultation with on-call pediatric infectious disease physician and SCAN on call physician is recommended. See Attachments # B-2.
f. Emergency contraception (Plan B) should be offered to all pubertal or postpubertal female victims. See Attachment # B-3.
g. Consult appropriate surgical subspecialist (Gynecology, Pediatric Surgery, or Pediatric Urology) in cases of severe anogenital injury.

10. Whenever possible, arrange medical follow-up according to the following schedule:

a. ~~In 1-2 days with PCP or Pat's Place Child Advocacy Center for further examination and photodocumentation of injuries;~~
b. In 1 month, 3 months, and 6 months with PCP, or appropriate specialist or caregiver for follow-up examination and testing for STD's, especially HIV.

11. Discuss and assist with referral for psychological counseling through Victim's Assistance, community mental health resources, and/or family's medical health plan. Crisis counseling for child and family is often necessary.

III. CHILD NEGLECT

A. Identification

Growth parameters below expected for age.

1. Lack of medical care for a significant health problem—for example, no medications for asthma, diabetes; no care of severe dental caries.

2. Lack of normal bonding with parent/guardian.

3. Disregard of one or more basic child care needs—for example, not feeding infant/child, child found in street, failure to place child in auto safety seat or belt.

Note: A child may have findings suggesting more than one form of abuse or neglect.

B. Essential Aspects - Caretaker History

1. Does the parent/guardian give a reasonable explanation that is consistent with the pattern and severity of the findings suggesting neglect (and can he/she provide documentation)? For example—has a child who is small for age been worked up for medical or familial causes of short stature/failure to thrive?

C. Evaluation & Treatment

1. Age 0-2 years: skeletal survey should be considered.
2. Nuclear medicine bone scan (or repeat skeletal survey in 2 weeks) if index of suspicion for skeletal injury remains high despite negative initial skeletal survey.
3. MRI scan of head if there is a suspicion for subacute or chronic intracranial injury.
4. Complete physical examination, including inspection of genitalia and search for dysmorphic features.
5. Developmental assessment.
6. Laboratory evaluation: CBC, electrolytes, glucose, urinalysis, urine C&S. Other labs as indicated clinically (e.g., lead level).
7. Nutrition consult/assessment with caloric quantification if possible.
8. Other consults as indicated clinically.
9. Document child's caloric intake, weight gain, and response to hospital staff.
10. Document level of parental involvement and any concerns regarding inappropriate parental behaviors, attachment, statements, or level of knowledge regarding the child, his/her care, or his/her condition.

ATTACHMENTS:

B-1. Presumptive Treatment of STDs in Sexual Assault Victims
B-2. HIV Prophylaxis
B-3. Guidelines for Emergency Contraception

Attachment # B-1

Presumptive Treatment of STD's in Sexual Assault Victims (adapted from CDC Guidelines, 2006)

Children: The risk of a child acquiring an STD as a result of sexual abuse or assault has not been determined. Presumptive treatment for children who have been sexually assaulted or abused is not recommended because: a) the prevalence of most STDs is low following abuse/assault, b) pre-pubertal girls appear to be at lower risk for ascending infection than adolescent or adult women, and c) regular follow-up of children usually can be ensured. However, some children or their parent(s) or guardian(s) may be concerned about the possibility of infection with an STD, even if the risk is perceived to be low by the health-care provider. Such concerns may be an appropriate indication for presumptive treatment in some settings and may be considered after all specimens for diagnostic tests relevant to the investigation have been collected.

Adolescents: Many specialists recommend routine preventive therapy after a sexual assault because follow-up of survivors of sexual assault can be difficult and because these persons may be reassured if offered treatment or prophylaxis for possible infection. The following prophylactic regimen is suggested as preventive therapy.

- Postexposure hepatitis B vaccination, without HBIG, should adequately protect against HBV. Hepatitis B vaccine should be administered to sexual assault victims at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered 1--2 and 4--6 months after the first dose.
- An empiric antimicrobial regimen for chlamydia, gonorrhea, trichomonas, and BV may be administered.

Recommended Regimen:

Follow 206 CDC guidelines (refer to www.cdc.gov)

NOTE: For patients requiring alternative treatments, see the sections in this report that specifically address the appropriate agent. The efficacy of these regimens in preventing gonorrhea, trichomoniasis, BV, and *C. trachomatis* genitourinary infections after sexual assault has not been evaluated. Clinicians should counsel patients regarding the possible benefits, as well as the possible toxicity, associated with these treatment regimens; gastrointestinal side effects can occur with this combination. Providers may also consider anti-emetic medications if prophylaxis is administered, particularly if emergency contraception is also provided.

Other Management Considerations

At the initial examination and, if indicated, at follow-up examinations, patients should be counseled regarding the following:

- symptoms of STDs and the need for immediate examination if symptoms occur and abstinence from sexual intercourse until STD prophylactic treatment is completed.

Attachment # B-2

HIV prophylaxis *(Nonoccupational Postexposure Prophylaxis = nPEP)*[1]

HIV infection has been reported in children whose only known risk factor was sexual abuse. Serologic testing for HIV infection should be considered for abused children. The decision to test for HIV infection should be made on a case-by-case basis, depending on the likelihood of infection among assailant(s). Data are insufficient concerning the efficacy and safety of postexposure prophylaxis among both children and adults. However, antiretroviral treatment (*a 28-day course of highly active antiretroviral therapy –HAART),* is well tolerated by infants and children with and without HIV infection; in addition, children who receive such treatment have a minimal risk for serious adverse reactions because of the short period of time recommended for prophylaxis.

In those cases in which a child presents to a health-care provider shortly after a sexual exposure (i.e., within 72 hours), the assailant(s) are likely to be at risk for HIV infection, and likelihood of compliance with treatment regimens is high, the potential benefit of treating a sexually abused child should be weighed against the risk for adverse reactions. **If antiretroviral postexposure prophylaxis is being considered, a professional specializing in HIV-infected children should be consulted.** If treatment is started, then medication should be given for the full 28 day course of therapy.

Recommendations for Postexposure Assessment of Children within 72 Hours of Sexual Assault

- Review HIV/AIDS local epidemiology and assess risk for HIV infection in the assailant.
- Evaluate circumstances of assault that may affect risk for HIV transmission.
- Consult with a specialist in treating HIV-infected children if postexposure prophylaxis is considered.
- If the child appears to be at risk for HIV transmission from the assault, discuss postexposure prophylaxis with the caregiver(s), including its toxicity and its unknown efficacy.
- If caregivers choose for the child to receive antiretroviral postexposure prophylaxis, provide enough medication until the return visit at 3--7 days after initial assessment to reevaluate child and to assess tolerance of medication; dosages should not exceed those for adults.
- Perform HIV antibody test at original assessment, 6 weeks, 3 months, and 6 months.

Recommendations for Postexposure Assessment of Adolescent and Adult Survivors within 72 hours of Sexual Assault

- Review HIV/AIDS local epidemiology and assess risk for HIV infection in assailant.
- Evaluate circumstances of assault that may affect risk for HIV transmission.
- Consult with a specialist in HIV treatment if postexposure prophylaxis is considered.

- If the survivor appears to be at risk for HIV transmission from the assault, discuss antiretroviral prophylaxis, including toxicity and unknown efficacy.
- If the survivor chooses to receive antiretroviral postexposure prophylaxis, provide enough medication to last until the next return visit; reevaluate survivor 3--7 days after initial assessment and assess tolerance of medications.
- Perform HIV antibody test at original assessment; repeat at 6 weeks, 3 months, and 6 months.

Assistance with postexposure prophylaxis decisions can be obtained by calling the National HIV Telephone Consultation Service (tel: 800-933-3413)

1. U.S. Department of Health and Human Services. Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States. *MMWR.* January 21, 2005 /.54(RR02);1-20.

Attachment # B-3 Emergency Contraception

Plan B is an emergency contraceptive that can be used to prevent pregnancy following unprotected intercourse. Each Plan B packet includes a single course of treatment and consists of two tablets; each tablet contains 0.75 mg levonorgestrel.

To obtain optimal efficacy, the first tablet should be taken as soon as possible within 72 hours of intercourse. The second tablet must be taken 12 hours later.

Taken within 72 hours of unprotected intercourse, Plan B can, when used correctly, reduce the risk of pregnancy by 89 percent after a single act of unprotected sex. Effectiveness declines as the interval between intercourse and the start of treatment increases

When used as directed, Plan B is safe for most women. There have been no serious complications associated with Plan B. Common side effects include nausea, abdominal pain, fatigue, headache, and menstrual changes. Women who are pregnant, have undiagnosed vaginal bleeding, or have an allergy to the product should not use Plan B. Plan B cannot terminate an established pregnancy.

Use of Yuzpe Regimen using other oral contraceptives is acceptable Emergency Contraception if plan B is not available.

Patient should be advised to obtain pregnancy test if no vaginal bleeding in 28 days after completing Emergency Contraception.

NORTH CAROLINA AND SOUTH CAROLINA DSS AGENCIES

You must call the Department of Social Services in the county that the child is a permanent resident of. Numbers for each county are listed below.

COUNTY	PHONE	ADDRESS
Anson	(704) 694-9351 CPS Intake	118 N. Washington St Wadesboro, NC 28170
Burke	(828) 439-2003	700 East Parker Rd. Morganton, NC 28680
Cabarrus	(704) 920-1400	1303 S. Cannon Blvd. Kannapolis, NC 28083
Caldwell	(828) 426-8200	1966-H Morganton Blvd. SW Lenoir, NC 28645
Catawba	(828) 324-9111	3030 Eleventh Ave. Dr., S.E. Hickc NC
Chester	(803) 377-8131 ext. 0	115 Reedy Street Chester, SC 29706
Chesterfield	(843) 623-2147 ext. 1	201 N. Page Street Chesterfield, SC 29709
Gaston	(704) 862-7500 ext. 1	330 N. Marietta Street Gastonia, NC 28052
Iredell	(704) 873-5631	PO Box 1146 Statesville, NC 28687
Lancaster	(803) 286-6914	1837 Pageland Highway Human Services Complex Lancaster, SC 29721
Lincoln	(704) 732-0738	PO Box 130, Lincolnton, NC 28093
Mecklenburg	(704) 336-3150	Wallace H. Kuralt Centre, 301 Billingsley Rd. Charlotte, NC 28211
Richmond	(910) 997-8415	125 Caroline St., Rockingham, NC 28379
Rowan	(704) 638-3175	1236 West Innes Street, Salisbury, NC 28144
Stanly	(704) 982-6100	1000 North First Street, Suite 2, Albemarle, NC 28001
Union	(704) 296-4300	1212 West Roosevelt Blvd. Monroe, NC 28111
York	(803) 684-2315 Dial 0 and ask for CPS Intake	P O Box 261 York, SC 29745

North Carolina and South Carolina Law Enforcement Agencies

Anson County
Sheriff's Office
119 N Washington St
Wadesboro, North Carolina 28170
(704)694-4188

Burke County
Sheriff's Office
150 Government Dr
Morganton, North Carolina 28655
(828)438-5500

Cabarrus County
Sheriff's Office
25 Corban Ave SE
Concord, North Carolina 28025
(704) 920-3000

Caldwell County
Sheriff's Office
2351 Morgantown Blvd. SW
Lenoir, North Carolina 28645
(828) 758-2324

Catawba County
Sheriff's Office
100 B Southwest Blvd
Newton, North Carolina 28658
(828) 464-5241

Cleveland County
Sheriff's Office
100 Justice Place
Shelby, North Carolina 28150
(704)484-4888

Gaston County
Sheriff's Office
PO Box 1578
Gastonia, North Carolina 28054
(704)866-3160

Guilford County
Sheriff's Office
400 W Washington St
Greensboro, North Carolina 27401
(336) 641-3690

Iredell County
Sheriff's Office
PO Box 287
Statesville, North Carolina 28687
(704)878-3180

Lincoln County
Sheriff's Office
700 John Howell Memorial Dr.
Lincolnton, North Carolina 28092
(704)732-9050

Mecklenburg County
Sheriff's Office
700 E 4th St
Charlotte, North Carolina 28202
(704)336-2543

OR Charlotte Mecklenburg Police Department
704-353-1000 or 911

Richmond County
Sheriff's Office
#1 Court St
Rockingham, North Carolina 28379
(910)997-8283

Rockingham County
Sheriff's Office
1086 NC 65
Wentworth, North Carolina 27375
(336)634-3232

Rowan County
Sheriff's Office
232 N Main St
Salisbury, North Carolina 28144
(704)636-1011

Rutherford County
Sheriff's Office
198 N Washington St
Rutherfordton, North Carolina 28139

Union County
Sheriff's Office
3344 Presson Rd
Monroe, North Carolina 28112

Stanly County
Sheriff's Office
201 S. Second Street
Albemarle, North Carolina 28001
(704) 283-3844

Union County
Sheriff's Office
3344 Presson Road
Monroe, North Carolina 28607
(704) 283-3844

Watauga County
Sheriff's Office
330 Queen St
Boone, North Carolina 28607

South Carolina Agencies

Chester County
P.O. Box 727
Chester, SC 29706-0727
(803) 581-5131

Chesterfield County
Courthouse, 200 W. Main St
Chesterfield, SC 29709
(843) 623-2101

Lancaster County
P.O. Box 908
Lancaster, SC 29721-0908
(803) 283-4186

York County
1675-2A York Highway
York, SC 29745
(803) 628-3059

10-18-2000 11:35am From-DISTRICT COURT JUDGES 7049428121 T-OC P 002/003 F-051

STATE OF NORTH CAROLINA

IN THE GENERAL COURT OF JUSTICE

COUNTY OF MECKLENBURG

DISTRICT COURT DIVISION

ADMINISTRATIVE ORDER

RETENTION OF CUSTODY OF JUVENILE SUSPECTED TO BE ABUSED PURSUANT TO NCGS §7B-308

BY_____

Pursuant to North Carolina General Statutes §7B-308, it is hereby ordered that Carolinas Medical Center, Presbyterian Hospital, Mercy Hospital, Mercy Hospital South, University Hospital and Presbyterian Matthews Hospital are authorized to retain custody of a juvenile (anyone under the age of 18) when the examining physician certifies in writing that the juvenile is suspected of being abused and: (a) that the juvenile should remain for medical treatment; or (b) that according to the juvenile's medical evaluation, it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker.

Custody assumed by this authority may not exceed twelve hours from the time and date contained in the Examining Physician's Certification without an additional Court Order.

When this action is taken, the physician or administrator of the hospital shall immediately notify the parent, guardian, custodian or caretaker of the juvenile and the Director of the Department of Social Services or his designee.

The purpose of this order is to allow for the legal retention of custody in emergency cases long enough for the Department of Social Services to investigate the case and, if appropriate, seek a Court Order for custody in accordance with North Carolina law.

Examining physicians shall utilize the Examining Physician's Certification form on the reverse side of this page whenever a juvenile is retained under the authority of this Order.

A copy of the Examining Physician's Certification must be given to the juvenile's parent, guardian, custodian or caretaker; the Department of Social Services; and the Chief District Court Judge (700 E. 4th Street, Suite 3304, Charlotte, North Carolina 28202), for placement in the juvenile's judicial records.

A copy of this Administrative Order must also be given to the parent(s), guardian, custodian or caretaker.

Each hospital shall maintain a file containing copies of all Examining Physician's Certifications executed under the authority of this Order at that hospital.

This Order replaces the Letter of Authorization issued October 5, 1993, by then Chief District Court Judge James E. Lanning.

This the 18 day of October, 2000.

William G. Jones
Chief District Court Judge

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002654

EXAMINING PHYSICIAN'S CERTIFICATION

Name of Juvenile: _____ Date of Birth: _____

Address: _____

_____

Name of Parent, Guardian, Custodian or Caretaker: _____

_____

Address: _____

_____

The undersigned examining physician hereby certifies that there is good cause to suspect that this juvenile is abused, and:

☐ should remain in _____ (name of facility) for medical treatment;

OR

☐ it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker.

The basis for this determination is:

_____

_____

_____

Date: _____ _____
Examining Physician

Time: _____

The juvenile's parent, guardian, custodian or caretaker was given an executed copy of this certification at _____ a.m./p.m. on _____.
(date)

DSS was notified of the execution of this certificate at _____ a.m./p.m. on _____.
(date)

An executed copy of this certificate was mailed to the Chief District Court Judge at 700 E. 4th Street, Suite 3304, Charlotte, NC 28202 on _____.
(date)

Attachment D
PR 110.03, Juveniles Suspected of Being Abused or Neglected

CERTIFICATION OF NECESSITY FOR RETENTION OF CUSTODY

Name of Juvenile: _____ Age: _____

Address of Juvenile: _____

_____

Name of Parent, Guarding, or Custodian: _____

Address: _____

_____

The undersigned physician has examined this juvenile and that examination reveals the following injuries / illness.

_____

_____

_____

_____

Based on the foregoing and additional facts set out below, the undersigned physician hereby certifies that:

☐ This juvenile should remain in _____ (name of facility) for medical treatment.

☐ In my medical evaluation, it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker.

Additional reasons (if any) for retention of custody:

_____

_____

_____

_____

Date: _____

Time: _____ Signature: _____

Carolinas HealthCare System
CERTIFICATION OF NECESSITY FOR RETENTION OF CUSTODY

ADDRESSOGRAPH PLATE

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002656

PR 110.03, revised 05/11

Attachment E

CHAPTER 90. MEDICINE AND ALLIED OCCUPATIONS
ARTICLE 1A. TREATMENT OF MINORS
PART 1. GENERAL PROVISIONS

Go to the North Carolina Code Archive Directory

N.C. Gen. Stat. § 90-21.5 (2010)

§ 90-21.5. Minor's consent sufficient for certain medical health services

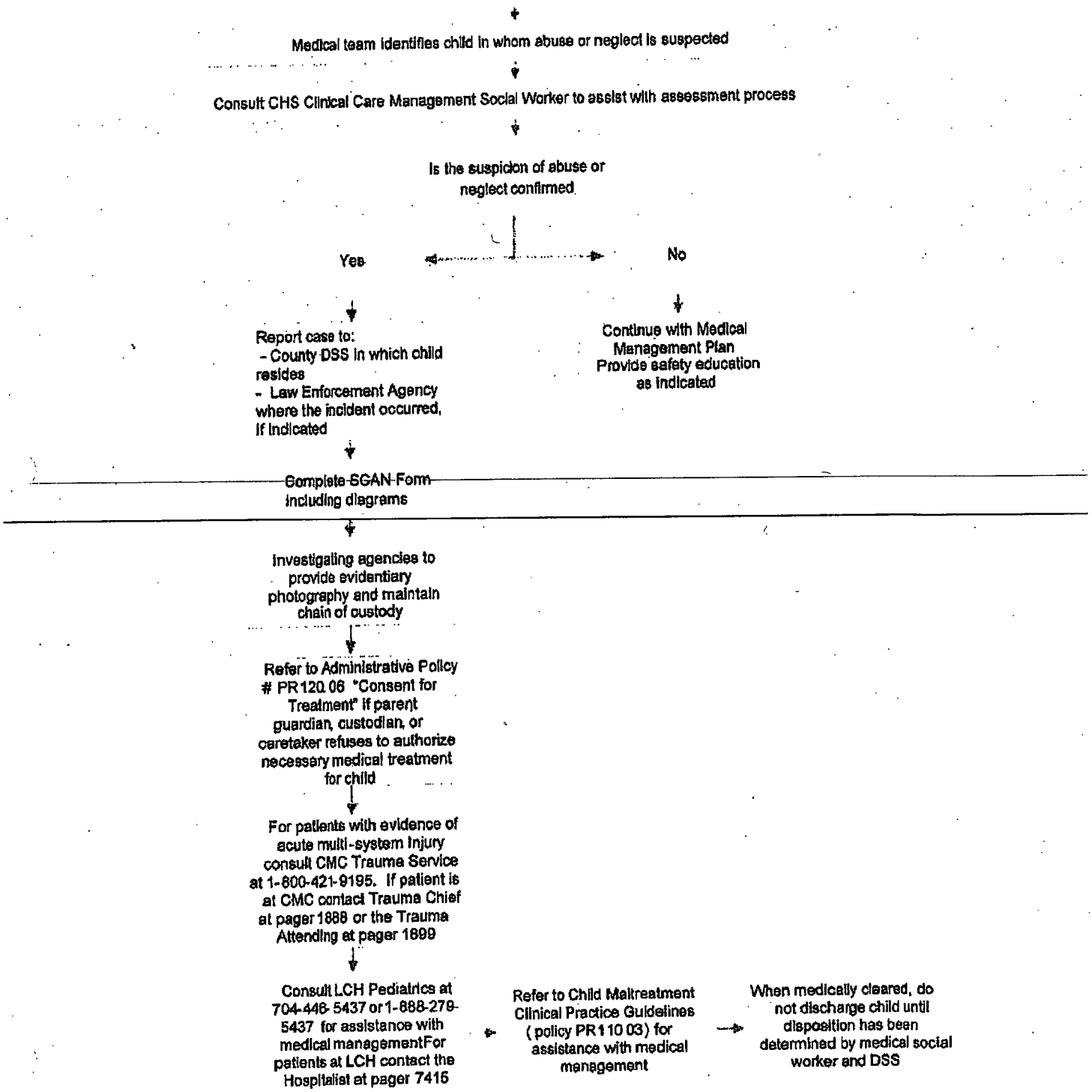
(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-223. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-223.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.

HISTORY: 1971, c. 35; 1977, c. 582, s. 2; 1983, c. 302, s. 2; 1985, c. 589, s. 31; 1985 (Reg. Sess., 1986), c. 863, s. 4; 2009-570, s. 10.

Attachment F

Child Abuse and Neglect Algorithm



EXHIBIT

"7"

Pediatrics
pediatrics.aappublications.org

Pediatrics Vol. 119 No. 6 June 1, 2007
pp. 1232 -1241
(doi: 10.1542/peds.2007-0883)

A statement of reaffirmation for this policy was published on 130 (2): e467.

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Evaluation of Suspected Child Physical Abuse

Nancy D. Kellogg, MD, and the Committee on Child Abuse and Neglect

ABSTRACT

This report provides guidance in the clinical approach to the evaluation of suspected physical abuse in children. The medical assessment is outlined with respect to obtaining a history, physical examination, and appropriate ancillary testing. The role of the physician may encompass reporting suspected abuse; assessing the consistency of the explanation, the child's developmental capabilities, and the characteristics of the injury or injuries; and coordination with other professionals to provide immediate and long-term treatment and follow-up for victims. Accurate and timely diagnosis of children who are suspected victims of abuse can ensure appropriate evaluation, investigation, and outcomes for these children and their families.

Key Words: physical abuse • child • child abuse • injury • evaluation

PREVALENCE

In 2004, 152250 children and adolescents were confirmed victims of physical abuse in the United States.[1] Of the 4 types of child maltreatment (neglect, physical abuse, sexual abuse, and emotional abuse), physical abuse is second to neglect, constituting approximately 18% of the total.[1]

Despite these statistics, the estimated number of victims is much higher; in 1 retrospective cohort study of 8613 adults, 26.4% reported they were pushed, grabbed, or slapped; had something thrown at them; or were hit so hard they got marks or bruises at some time during their childhood.[2] It has been estimated that 1.3% to 15% of childhood injuries that result in emergency department visits are caused by abuse.[3] Physical abuse remains an underreported (and often undetected) problem for several reasons including individual and community variations in what is considered "abuse," inadequate knowledge and training among professionals in the recognition of abusive injuries, unwillingness to report suspected abuse, and professional bias. For example, in 1 study,[4] 31% of children and infants with abusive head trauma were initially misdiagnosed. Misdiagnosed victims were more likely to be younger, white, have less severe symptoms, and live with both parents when compared with abused children who were not initially misdiagnosed. Such studies suggest a need for practitioners to be vigilant to the possibility of abuse when evaluating children who have atypical accidental injuries or obscure symptoms that are suggestive of traumatic etiologies but who do not have a history of trauma.

Child abuse has significant long-term medical and mental health morbidity.[5] Children with abusive head or abdominal injuries are more likely to die or become more severely incapacitated than are children with head or abdominal injuries caused by accidents.[6–8] Victims of physical abuse in childhood are more likely to develop a variety of behavioral and functional problems including conduct disorders, physically aggressive behaviors, poor academic performance, and decreased cognitive functioning.[9,10] Additional problems include anxiety and depression, as well as social and relationship deficits.

CHARACTERISTICS OF VICTIMS AND RISK FACTORS

Child physical abuse affects children of all ages, genders, ethnicities, and socioeconomic groups. Male and female children experience similar rates of physical abuse. In 1 survey study of more than 2000 children and adolescents,[11] 15% of adolescents received injuries from a physical assault and were more likely than children in younger age groups to receive injuries from abuse. Although the risk of physical abuse increases with age, fatal abuse and serious abusive injuries are more common among children and infants younger than 2 years.[1] Children in homes with annual incomes of less than $15000 per year have 3 times the number of fatalities, 7 times the number of serious inflicted injuries, and 5 times the number of moderate inflicted injuries when compared with children living in homes with annual incomes of greater than $15000 per year.[12] Risk factors for infant maltreatment include maternal smoking, the presence of more than 2 siblings, low infant birth weight, and an unmarried mother.[13] One study found that children living in households with unrelated adults were approximately 50 times more likely to die of inflicted injuries than were children residing with 2 biological parents.[14] The US Department of Health and Human Services has indicated that the rate of physical abuse is 2.1 times higher among children with disabilities than children without disabilities.[15] The presence of risk factors should not be used as indicators of child abuse but rather to provide guidance in prevention strategies as well as management and treatment plans.

ROLE OF THE PEDIATRICIAN

The role of the pediatrician encompasses prevention of abuse and detection and medical management of victims of abuse. Accurate identification of children who are suspected victims of abuse can facilitate appropriate evaluation, referral, investigation, and outcomes for these children and their families.[16] Children usually sustain abuse at the hands of a caregiver who misinterprets and responds inappropriately to the child's behavior. For example, caregivers who had smothered, shook, or slapped their infant within the first 6 months of life were more likely to be worried about crying and to believe that their infants cried excessively.[17] There is a close correlation between the age-specific incidence curve of infants hospitalized with abusive head trauma and the age-specific normal crying behavior of infants up to 36 weeks of age.[18]

In an anonymous telephone survey of 1435 mothers, 2.6% of children younger than 2 years were shaken by their mothers as a means of discipline.[19] Caregivers may respond inappropriately to their child's behavior when they are unduly stressed. Poverty, significant life events, and caregiver role conflicts are stressors that are often associated with abuse.[14] Pediatricians can effectively educate parents regarding the range of normal behaviors in infants and children, provide anticipatory guidance, and be a resource when the behavior becomes unmanageable for parents. In addition, pediatricians can screen for adult-partner violence; in 1 study, child abuse was 4.9 times more likely in families with identified spouse abuse than in families without identified spouse abuse.[20] Other conditions that place children at risk of being abused, such as maternal depression or drug abuse, may also be identified.

Careful medical assessment, detection of suspicious injuries, and reporting of abuse may prevent further abusive trauma in infants and adults.[1] In 1 study of abuse victims younger than 24 months, 75% had evidence of previous trauma or history of a previous injury.[21] Child abuse may recur 35% of the time without appropriate detection and intervention.[22]

As with other types of child maltreatment, there have been recent advances in medical knowledge regarding physical abuse. Most recent developments have addressed more accurate differentiation between inflicted and accidental injuries as well as detecting conditions that may mimic abusive injuries. Although consideration of nonabusive causes of injuries may merit additional evaluation and testing, the physician is mandated by law to report suspicions of abuse and should not delay reporting pending confirmatory testing or information. In all states, the law also provides some type of immunity for good-faith reporting. Once a suspected victim is identified and further assessment and management is required, using a pediatric child abuse consultant, if available, early in this process may obviate the need for invasive or expensive testing and can help direct the pediatrician toward appropriate evaluation. The

detection and diagnosis of child physical abuse depends on the clinician's ability to recognize suspicious injuries, conduct a careful and complete physical examination with judicious use of auxiliary tests, and consider whether the caregivers' explanation is supported by the characteristics of the injury or injuries and the child's developmental capabilities. The physician should also ensure that the child's immediate medical and safety needs are met. Child abuse injuries, particularly traumatic brain injuries, may result in significant long-term disabilities including learning deficits, attention-deficit/hyperactivity disorder, behavioral problems, seizures, spasticity, blindness, paralysis, and mental retardation.[23,24] Continuity of care for such children is essential, especially if they are transferred to other caregivers or foster homes.

Many hospitals and communities have developed child abuse-assessment teams of pediatricians and other professionals who specialize in the assessment of suspected victims of child abuse.[25] Such teams usually have access to additional information from law enforcement and child protective services, such as scene investigation, that may facilitate more thorough injury assessment and diagnosis. Involving such teams early in the process can ensure accurate and comprehensive assessments and information sharing among the medical and nonmedical disciplines involved and can provide for intermediate and long-term management of the child and family. Pediatricians with expertise in evaluating suspected abuse should provide training and assistance to emergency physicians and other first responders to enhance detection and appropriate referral of these patients.

Many regions do not have specialized child abuse teams but do have physicians with expertise in child abuse. Pediatricians should know which hospitals in their region have the most available expertise in the emergency evaluation of suspected child abuse. In turn, pediatricians with expertise in child abuse often act as consultants for emergency departments and child protective services. Close collaboration is necessary, particularly for establishing how the child should be transported between facilities, who should notify child protective services, who should notify the caregiver(s) of suspected abuse and when, and whether law enforcement should be notified. For those who do not require emergent transportation by ambulance, child protective services may facilitate transportation of a suspected child victim from one facility to another, assist in notifying the caregivers and law enforcement of suspected abuse, and provide an emergent safety plan on hospital discharge or clinic dismissal.

DEFINITIONS

The recognition and reporting of physical abuse is hindered by the lack of uniform or clear definitions. Many state statutes use words such as "risk of harm," "substantial harm," "substantial risk," or "reasonable discipline" without further clarification of these terms. Many states still permit the use of corporal punishment with an instrument in schools; on the other hand, the American Academy of Pediatrics has proposed that "striking a child with an object" is a type of physical punishment that "should never be used"[19] and has recommended that corporal punishment be abolished in schools.[27] The variability and disparities in definitions may hinder consistent reporting practices.

CLINICAL PRESENTATIONS AND SETTINGS

Most physical abuse injuries are likely to not be detected or reported. Minor injuries may not require medical attention and may be obscure or hidden. Infants and children are reported as suspected victims of physical abuse when 1 or more of the following occurs: an individual (including a professional) sees and reports a suspicious injury; an individual witnesses an abusive event; a caregiver observes symptoms and brings the child in for medical care but is unaware that the child has sustained an injury; an individual asks a child if he or she has been hurt in an abusive way; the abuser thinks the inflicted injury is severe enough to require medical attention; or the child victim discloses abuse. The American Academy of Pediatrics has indicated that "hospitalization of children requiring evaluation and treatment for abuse or neglect should be viewed by third-party payors as medically necessary."[28]

The clinical approach to an infant or child with possible abusive injuries is not significantly different from standard pediatric care. As with all patients, a severely injured child must be stabilized before further evaluation is

undertaken. This initial evaluation may encompass a trauma response team and pediatric specialists in surgery, emergency medicine, and critical care. Careful documentation may not be possible initially and must always be secondary to resuscitation and stabilization of the patient. Once the child is stabilized, a careful and well-documented history, as always, is the most critical element of the medical evaluation. Using quotes whenever possible, the pediatrician should document descriptions of the mechanisms of injury or injuries, onset and progression of symptoms, and the child's developmental capabilities. The physical examination should include detailed documentation, either by body diagrams and/or photographs, of any concerning cutaneous findings and should include a thorough search for other signs that may suggest a nontraumatic cause. If the child is verbal, it may be helpful to gather parental and patient histories separately. If abuse is a concern after this preliminary evaluation, consultation with a child abuse pediatrician, pediatric specialist, or pediatrician experienced in this area, if available, may be helpful in determining the best way to proceed with assessment.

Physical discipline is commonly inflicted on areas of the body that are concealed by clothing (eg, back/buttocks). When inflicted injuries are visible or incidentally discovered, child victims and their abusers typically explain the injuries as accidental; if clinicians or professionals are not critical or skeptical of this information, the injuries may be incorrectly attributed to accidental causes. Other victims present with severe inflicted injuries that require medical care. The initial history is typically vague and/or benign and may become inconsistent as the investigation progresses.

MEDICAL HISTORY

The interview of parents or caregivers of infants or children who present with serious injuries may be conducted in an outpatient or inpatient setting. If the child presents to a clinic with a serious injury that requires further medical care in a specialty (eg, orthopedics) or hospital setting, the clinician may opt to gather the minimum information to establish a need for reporting to child protective services. Any statements made by the caregiver regarding the injury should be documented accurately and completely. Once the clinician has assessed all the injuries, including approximate ages of injuries (when possible), a careful, complete, and detailed history should be obtained from the caregivers.

Explanations that are concerning for intentional trauma include:

1. no explanation or vague explanation for a significant injury;
2. an important detail of the explanation changes dramatically;
3. an explanation that is inconsistent with the pattern, age, or severity of the injury or injuries;
4. an explanation that is inconsistent with the child's physical and/or developmental capabilities; and
5. different witnesses provide markedly different explanations for the injury or injuries.

Information regarding the child's behavior before, during, and after the injury occurred, including feeding times and levels of responsiveness, should be gathered. Victims of significant trauma usually have observable changes in behavior. Access to caregivers and caregiver activities before, during, and after the injury occurred are also important to document. Frequently, infants and children present to medical settings with a history of a fall. Recent studies have indicated that short falls may result in bruising; however, more significant types of head trauma, including skull fractures, are exceedingly uncommon but possible.[9,10]

Information should be gathered in a nonaccusatory but detailed manner. Other information that may be useful in the medical assessment of suspected physical abuse includes:

1. past medical history (trauma, hospitalizations, congenital conditions, chronic illnesses);

2. family history (especially of bleeding, bone disorders, and metabolic or genetic disorders);
3. pregnancy history (wanted/unwanted, planned/unplanned, prenatal care, postnatal complications, postpartum depression, delivery in nonhospital settings);
4. familial patterns of discipline;
5. child temperament (easy to care for or fussy child);
6. history of past abuse to child, siblings, or parents;
7. developmental history of child (language, gross motor, fine motor, psychosocial milestones);
8. substance abuse by any caregivers or people living in the home;
9. social and financial stressors and resources; and
10. violent interactions among other family members.

PHYSICAL EXAMINATION

Most injuries of childhood are not the result of abuse or neglect. Minor injuries in children are exceedingly common. Physicians must also consider that unusual events, including accidents, do happen to children[31] and may produce injuries that are not characteristically seen from accidental causes. An injury pattern is rarely pathognomonic for abuse or accident without careful consideration of the explanation provided. In addition, both inflicted and accidental injuries may be seen simultaneously in a child.

General Assessment

The child's alertness and demeanor may reflect neurologic status and degree of discomfort and pain. A thorough and complete neurologic examination must be performed. For example, if alertness appears compromised, eye-opening, verbal, and motor responses should be assessed systematically. Spontaneous and symmetrical movement of all extremities should be noted, as well as any of the child's responses that indicate pain when extremities are examined and moved. Because abusive caregivers are rarely informative regarding the injuries that have been inflicted, special care should be taken during the examination of the child's extremities and neck, which may be fractured and require immobilization until diagnostic radiographs can be performed. Evidence of spinal cord injury, such as abnormal reflexes, muscle tone, or responsiveness to tactile stimuli, should be carefully pursued.

When the child is stable, height, weight, and fronto-occipital circumference should be carefully measured and then plotted on a growth chart. Previous measurements obtained from past medical visits should also be obtained to gauge whether growth velocity has been appropriate. Plotting parameters is essential, because clinicians may miss significant growth failure in infants and children if the clinician relies only on their clinical impressions. Physical abuse and failure to thrive are sometimes concurrent[32,33]; in addition, some children are starved intentionally.[34]

Evidence of neglect may be seen during the general examination of the infant or child; extensive dental caries, severe diaper dermatitis, or neglected wound care may be noted in addition to injuries that raise suspicion of abuse. Bald areas on the scalp may sometimes be seen with severe nutritional deficits or with traumatic alopecia. These findings should be differentiated from nonabusive or benign causes such as tinea capitis, alopecia areata, and occipital bald spots caused by supine positioning of young infants.

If the child can be interviewed, his or her demeanor should be noted during questioning. Some children display strong nonverbal cues of anxiety and reluctance when answering questions regarding potential abuse, because they are protective of their abuser or they fear retribution for "telling." Others may appear openly fearful of their abuser. Such responses may be important to consider when a safety plan for the child is made.

Skin Injuries

Location, size, and shape of any bruises, lacerations, burns, bites, or other skin injuries should be documented in a medical chart as well as with high-quality 35-mm or digital photographs. Inspection for injuries should be thorough and involve all aspects of the neck and head; mouth; extremities, including feet and hands; genitals; anus; buttocks; torso; and back. Obscure sites for inflicted injuries include the ears, especially the posterior aspects, the neck and angle of the jaw, scalp, and the frenula of the lip and tongue. In contrast to accidental injuries, inflicted injuries tend to occur on surfaces away from bony prominences, such as the neck, head, buttocks, trunk, hands, and upper arms.[35,36] In 1 patient series, approximately 60% of abused children had injuries on the head, face, or neck.[37] Hematomas of the scalp may be detected through palpation or may be visualized on radiographs. Some deeper bruises may not be readily visible for several hours; areas that are painful to palpate may require further examination in 1 to 2 days, when bruises may become apparent. Measurement of skin injuries may assist in determining the mechanism of injury and/or object used to inflict the injury. For example, a child that is kicked may have a discernable shoe imprint, or a knuckle imprint may be apparent if the child was punched.

Bite marks can yield important forensic information; referral to professionals that can gather such information and maintain a chain of custody is advisable.[38] Bite marks, recent or healed, should be carefully measured and photodocumented when possible; an intercanine distance of more than 2 cm suggests a human adult-sized bite.[39] In some facilities, forensic odontologists are available and may use special examination and photographic techniques to analyze bite marks. Fresh bites should be swabbed with sterile, premoistened cotton-tipped applicators for forensic analysis of potential genetic markers found in saliva.

The age of a bruise cannot be determined accurately.[40] Soft tissue swelling is seen more commonly with recent trauma but can persist for several days. The age and developmental capabilities of the infant or child also determine the frequency of bruising. For example, 1 study of infants and toddlers presenting for health maintenance examinations found that 17.8% of infants starting to "cruise" and 91.9% of ambulatory toddlers had bruises; bruises were observed only 2.2% of the time in infants who were not yet cruising.[35] In addition to accidents, bruising may occur secondary to coagulopathies and vasculitides such as idiopathic thrombocytopenic purpura, vitamin K deficiency, Henoch-Schönlein purpura, hemophilia, or von Willebrand disease.

Burn injuries may be chemical, thermal (including exposure to scalding liquids or hot objects), or electrical. The child's clothing worn during the burn should be collected and may provide information regarding the cause of the burn. Burns inflicted with hot objects can be difficult to differentiate from accidental mechanisms, because both burns may be patterned. The history, number of burns, and continuity of the burn pattern over curved body surfaces may indicate a greater probability of inflicted trauma. Accidental scalds most commonly involve hot liquids pulled or splashed onto the child's upper extremities, torso, and or neck and head.[41] Inflicted scalds or forced-immersion burns may be well demarcated in pattern, with few or no splash marks. When evaluating an apparent burn injury, other noninflicted causes to consider include chemical burns of the buttocks with senna-containing laxatives,[42] bullous impetigo, and accidents.

Cranial Injuries

Head trauma is the leading cause of child abuse fatalities.[43] When compared with child victims of severe accidents, children with abusive head trauma are more likely to have subdural and subarachnoid hematomas, multiple subdural hematomas of differing ages, more extensive retinal hemorrhages, and associated cutaneous, skeletal, and visceral injuries.[6] The inflicted injuries tend to occur in younger patients. Abusive head trauma tends to result in higher mortality and longer hospital stays than does accidental head trauma.[6,7] Infants with intracranial injuries frequently have no or nonspecific symptoms,[44,45] so the absence of neurologic symptoms should not exclude the need for imaging. Careful consideration of symptoms, signs, history, and judicious use of other ancillary tests should guide the clinician in determining the need for imaging.

Skull fractures can occur from accidents or inflicted injury. Studies have indicated that simple linear skull fractures can result from short falls of less than 3 ft and that such fractures are usually associated with scalp bruising or swelling.[46] However, it is unknown how many infants and children sustain skull

fractures from simple falls, are asymptomatic, and, therefore, never present for a medical evaluation; hence, the incidence of skull fractures among infants who sustain such falls is likely unknown. Abuse should be suspected when there is a history of minor head trauma such as a short fall in children with multiple, complex, diastatic, or occipital skull fractures.[47] Whenever an infant or child presents with a skull fracture, care should be taken to ensure that there are no other injuries.

Conditions that may be confused with abusive head trauma include glutaric aciduria type 1 (macrocranium, subdural hematoma, sparse intraretinal and preretinal hemorrhages, frontotemporal atrophy) and hemorrhagic disease of the newborn (including risk factors such as home birth, no vitamin K prophylaxis, or breastfeeding).

A fundoscopic examination for retinal hemorrhages should be considered for any infant or young child who is a suspected victim of physical abuse. Under optimal conditions, an ophthalmologist with pediatric experience should conduct an examination of dilated pupils by using indirect ophthalmoscopy. The ophthalmologist should provide documentation of the retinal hemorrhages by photography or detailed annotated drawings. Location, depth, and extent of retinal hemorrhages may distinguish between abusive and nonabusive causes of head trauma.[48] Retinal hemorrhages occur in approximately 85% of infants and children who are subjected to abusive, repetitive, acceleration-deceleration (shaking) forces with or without impact.[49] Although newborn infants may have retinal hemorrhages in the superficial nerve fiber layers, most resolve by 2 weeks of age, and most intraretinal hemorrhages resolve by 4 to 6 weeks of age.[49]

Thoracoabdominal Injuries

Inflicted injuries that involve the heart are rare and severe. Rib fractures in infants are usually caused by forceful squeezing of the chest[50]; posterior or lateral rib fractures or multiple rib fractures are especially predictive of abusive trauma.[51] Cardiopulmonary resuscitation, whether performed by experienced or inexperienced individuals, is an unlikely cause of rib fractures[52] or retinal hemorrhages. Acute rib fractures may be associated with shallow breathing attributable to pain and splinting; in severe cases, a fractured rib may puncture the lung. Alterations in respiratory patterns may also signal central nervous system damage or response to pain. Other rare injuries associated with abusive blows or compressive forces to the chest include hemopericardium, cardiac contusions occurring as a result of abusive blows to the chest, and shearing of the thoracic duct resulting in chylothorax.[53,54]

Auscultation, performed before palpation, may reveal decreased or no bowel sounds if the child has sustained intraabdominal injury. If the intestines, liver, or spleen have been ruptured, guarding or abdominal muscle rigidity may be noted on palpation. Abdominal bruising is often not seen, even with severe blows to the abdomen.[55] In 1 study,[56] solid organ injuries were most common in children with accidental and inflicted abdominal trauma, but abused children were more likely to have a hollow viscus injury or both hollow viscus and solid organ injuries than were children with accidental abdominal injuries. In comparison with children who sustain accidental trauma to the abdomen, victims of inflicted intraabdominal injury tend to be younger, are more likely to have delayed presentations to a clinical setting, have a higher mortality rate, and are more likely to have an injury to hollow viscera.[6] Liver and pancreatic enzyme tests are helpful in screening children for abdominal trauma, especially when the child presents with acute symptoms or shortly after the incident has occurred. A urinalysis may also lead to the discovery of unexpected trauma to the urinary tract and kidneys. Radiographic studies, including computed tomography, are helpful in determining the types and severity of intraabdominal trauma and are warranted in most cases when the physical examination is unreliable because of patient age, presence of other injuries that may obfuscate the abdominal examination, or the presence of head injury.

Skeletal Injuries

Careful palpation of the legs, arms, feet, hands, ribs, and head may reveal acute or healing (callus formation) fractures. If a fracture is suspected, surfaces should be carefully examined for "grab marks" that may indicate restraint or areas that were pulled or twisted to create the fracture; however, absence of such bruising does not exclude abusive mechanisms of injury. Soft tissue swelling, with or without bruising, may indicate more recent trauma. Many

fractures, including rib and metaphyseal fractures, may not be clinically detectable, so a negative clinical examination should not preclude the need for a skeletal radiologic survey when inflicted trauma is suspected, particularly in children younger than 2 years.

Long-bone fractures that should be evaluated carefully for nonaccidental causes include metaphyseal fractures and spiral/oblique fractures, especially in nonambulatory infants; both types of fractures have been associated with accidental mechanisms of injury as well. Accidental causes of lower-extremity spiral or oblique fractures have been described among infants in "exersaucers"[57] and in the tibia of newly ambulatory toddlers.[58] Osteogenesis imperfecta is a rare congenital disorder that typically presents with bone fragility. Other associated findings are common and include deep-blue sclera, ligamentous laxity, osteopenia, wormian skull bones, dentinogenesis imperfecta, positive family history, and hearing loss. Less common types of this disease may present with fewer and less-severe clinical symptoms.[59] Patients with osteogenesis imperfecta are often suspected as victims of abuse before diagnosis, because the history of the injury insufficiently explains the severity of the fracture, and osteopenia may be lacking in occult cases of this disease.[60]

A complete neurologic assessment, including reflexes, cranial nerves, sensorium, gross motor, and fine motor abilities, should be conducted. Abnormalities may reflect current or past injuries to the central nervous system. Abused children may also have developmental disabilities because of deprivation in the home environment or other causes.

DIAGNOSTIC TESTING AND CONSULTATIONS

When abuse is suspected as the cause of an injury, the clinician may conduct tests to screen for other injuries or underlying medical causes for the injury. The extent of diagnostic testing depends on several factors including the severity of the injury, the type of injury, the age of the child, and examination findings. In general, the more severe the injury and younger the child, the more extensive is the need for diagnostic testing for other injuries. Table 1 is a summary of tests, some of which may be used during a medical assessment for suspected abuse.

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TABLE 1

Diagnostic Tests That May Be Used in the Medical Assessment of Suspected Physical Abuse and Differential Diagnoses

When 1 child is identified as a suspected victim of abuse, siblings and other child contacts of the suspected abuser should also be assessed for injuries. The extent of the assessment depends on the child's age, symptoms, and signs; infants and toddlers may require more extensive testing, because symptoms and signs may be less useful in determining the presence of occult inflicted injuries.

DOCUMENTATION AND DIAGNOSTIC CONSIDERATIONS

Complete documentation of visible injuries on body diagrams and with photographs is strongly urged and facilitates peer review as well as court testimony, when required. In some regions, investigators from law enforcement or child protective services are specially trained to take forensic photographs. Diagnostic impressions should address whether the explanation adequately correlates with the severity, age, pattern, and distribution of the injury or injuries and the likelihood of nonaccidental causes for the injury. If a child has sustained a serious injury because he or she was left unsupervised in a dangerous environment, the physician should report suspected neglect or inappropriate adult supervision, including injuries sustained while under the care of an intoxicated adult, to child protective services.[69] When the child is evaluated or tested for other nonabusive causes, documentation should reflect the results of this assessment as well. In general, concern for abuse is greatest for infants younger than 12 months regardless of the severity of the injury.

TREATMENT

Once medical assessment and stabilization are achieved and a referral has been made to investigative agencies, the physician should ensure that the child receives the necessary follow-up services. The child's primary care physician should be notified, and child protective services should ensure that the family complies with the plan of care. These services should not only include referral to appropriate medical providers but also address the psychological effects of abuse or neglect on the young child, the siblings, and the nonoffending caregiver. Because adult-partner violence commonly co-occurs with child abuse, several family members may require medical and mental health assistance. Medical passports, which are abbreviated medical chart forms usually kept by foster parents and presented at each medical visit, are recommended to optimize treatment regimens in children who are shifted among agencies and individuals during the course of the child abuse investigation.[70]

LEGAL ISSUES

All 50 states have statutes that mandate reporting of suspected child abuse and neglect; the physician is not required to prove abuse before reporting. Familiarity with state laws will ensure that physicians report to the appropriate agency within the required time frame; some states have provided the option of making such a report through the Internet. Information on specific state laws are provided by the Children's Bureau (Administration for Children and Families, US Department of Health and Human Services; see www.childwelfare.gov/systemwide/laws_policies/search/index.cfm). Many states have laws that permit physicians to evaluate children who are suspected victims of abuse, to conduct tests, and to take photographs without parental consent.

The physician may be required to write a sworn statement of his or her findings and to testify in civil or criminal trial proceedings. Civil hearings include testimony about the safety of the child and the need for appropriate placement with caregivers or state agencies. Judgments are based on a "preponderance of the evidence" with respect to the likelihood of abuse. Criminal hearings involve testimony about the guilt or innocence of an individual with respect to causing the injuries in a child. The burden of proof is greater than that of civil hearings; cases must be proven "beyond a reasonable doubt." Physicians are expected to testify to the facts on the basis of their knowledge and experience in pediatrics and, when appropriate, in child abuse. As such, they may be asked to render opinions regarding the normal developmental capabilities of children at certain ages as well as the mechanisms of injury, severity of the injury, and prognosis. Pediatricians should not testify to anything that is beyond their level of knowledge or expertise. Physicians act primarily as scientists and educators in legal settings rather than as child advocates.

CONCLUSIONS

Child physical abuse is a common problem of childhood. The physician must be able to recognize suspicious injuries, conduct a comprehensive and careful examination with appropriate auxiliary tests, critically assess the explanation provided for the injury or injuries, and establish the probability that the explanation does or does not correlate with the pattern, severity, and/or age of the injury or injuries. The physician is responsible for reporting suspected abuse, documenting his or her opinions clearly, and providing the necessary information and expertise to investigative and legal personnel and parents, when appropriate. In addition, pediatricians are uniquely qualified to work with parents and caregivers to prevent abuse by providing anticipatory guidance on normal child behavior and its management. Finally, physicians must advocate that children in foster care who have medical or mental health problems receive the appropriate services and medications and continuity of care through a medical home, and that a medical passport is maintained for these children.

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FOOTNOTES

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.
The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate

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Responses to this article

Eye findings and Allegations of Shaking and Non-Accidental Injury
John G Galazniik
Pediatrics published online August 8, 2007
»Full Text

Statement of reaffirmation

From the American Academy of Pediatrics:
Policy Statement: AAP Publications Reaffirmed and Retired
Pediatrics 2012; 130:2 e467-e468; published ahead of print July 30, 2012, doi:10.1542/peds.2012-1359
»Extract »Full Text »Full Text (PDF)

Articles citing this article

Prevalence of Abusive Injuries in Siblings and Household Contacts of Physically Abused Children
Pediatrics 2012; 130:2 193-201
»Abstract »Full Text »Full Text (PDF)

Prevalence of Retinal Hemorrhages in Critically Ill Children
Pediatrics 2012; 129:6 e1388-e1396
»Abstract »Full Text »Full Text (PDF)

Symptoms and Time to Medical Care in Children With Accidental Extremity Fractures
Pediatrics 2012; 129:1 e126-e133
»Abstract »Full Text »Full Text (PDF)

Detection of child abuse in emergency departments: a multi-centre study
Arch. Dis. Child. 2011; 96:5 422-425
»Abstract »Full Text »Full Text (PDF)

Vitamin D Status in Abused and Nonabused Children Younger Than 2 Years Old With Fractures
Pediatrics 2011; 127:5 835-841
»Abstract »Full Text »Full Text (PDF)

Evaluation of the Siblings of Physically Abused Children: A Comparison of Child Protective Services Caseworkers and Child Abuse Physicians
Child Maltreat 2010; 15:2 144-151
»Abstract »Full Text (PDF)

Bruising Characteristics Discriminating Physical Child Abuse From Accidental Trauma
Pediatrics 2010; 125:1 67-74
»Abstract »Full Text »Full Text (PDF)

Child Abuse Fatalities: Pattern of Injury
AAP Grand Rounds 2009; 22:3 31
»Full Text »Full Text (PDF)

Utility of Hepatic Transaminases to Recognize Abuse in Children
Pediatrics 2009; 124:2 509-516
»Abstract »Full Text »Full Text (PDF)

Multiple fractures due to osteogenesis imperfecta mistaken as child abuse
BMJ Case Reports 2009; 2009:mar19_1 bcr0720080589
»Abstract »Full Text

Forty years later: inconsistencies in reporting of child abuse
Arch. Dis. Child. 2008; 93:10 822-824
»Full Text »Full Text (PDF)

Medical Conditions Affecting Sports Participation
Pediatrics 2008; 121:4 841-848
»Abstract »Full Text »Full Text (PDF)

Diagnostic Evaluation for Suspected Child Abuse
JWatch Pediatrics 2007; 2007:620 4
»Full Text

Uncovering child abuse: Physical abuse is an underreported and often unnoticed problem. A new clinical report outlines the critical components of the medical assessment.
AAP News 2007; 28:6 9-10
»Full Text »Full Text (PDF)

EXHIBIT

"8"

Carolinas Patient Care Discharge Planning Process

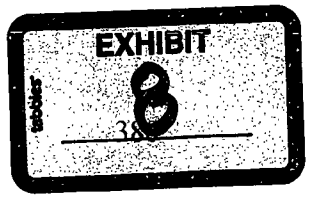
Sun Dec 06, 2009 05:30 pm

count No	Name	Unit Number	Birthdate
339-00393	[redacted] OWEN [redacted]	000545-02 19	[redacted]

1)Date : 12/06/09
2)Init : KAH
3)Planning Code : CPSI-CPSI-CHILD PROT SVC INITIAL REFER
4)Referred From : LCH

1 2 3 4 5 6 7
1234567890123456789012345678901234567890123456789012345678901234

1206/2009 ~1500 MSW received page re r/o NAT, work-up is negative for NAT but pt does have a small subdural hematoma. Sara, RN reports that parents have been appropriate, grandparents have been visiting. MSW met c parents, mom is Kayla Lythgoe, dad is Michael Carcuff, baby lives c both parents. Baby lives at [redacted], Rock Hill, SC 29732, parents do not have a home phone, only a cell phone c texting, [redacted], phone # [redacted] listed on demographic sheet belongs to MGM Charlotte Williams [redacted] Pt's parents report that on Weds. 12/02/2009, parents noticed that baby "not seeming like himself, sleepy more than usual" "screaming non-stop" "funky smell out of his mouth" took the baby to Sunshine Pediatrics, to see Dr. Paxton, who told the parents that it was a viral infection and to give the baby Tylenol every 6 hours. On Friday night 12/04/2009 [note con
dit Notes (Y/N)?-



Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 05:41 pm

Account No	Name	Unit Number	Birthdate
)9339-00393	[redacted], OWEN [redacted]	000545-02-9	[redacted]

(1)Date : 12/06/09
(2)Init : KAH
(3)Planning Code : CPSI-CPSI-CHILD PROT SVC INITIAL REFER
(4)Referred From : LCH

1 2 3 4 5 6 7
1234567890123456789012345678901234567890123456789012345678901234

01 12/06/2009 MSW note continued...after she staffs the case c her supervisor
02 Baby is not for d/c today, possibly will be d/ced tomorrow. Baby does have
03 SC Medicaid, WIC, mom has foodstamps. Both parents work, MGM watches baby
04 when parents are working. Pt's bedside RN Sara did report that MGM did
05 tell her privately that when she had picked baby up from dad and uncle
06 that she noticed baby had a bump on his head, she asked dad and uncle
07 about this and dad and uncle stated that they had no idea why this
08 happened. MSW will leave note for weekday MSW.
09
10 Katie Harrison, MSW p 2537
11
12

Edit Notes (Y/N)?--

CMC (12.05.09) 0096

Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 06:44 pm

Account No	Name	Unit Number	Birthdate
09339-00393	[redacted].OWEN [redacted]	000545-02-19	[redacted]

(1)Date : 12/06/09
(2)Init : KAH
(3)Planning Code : CPSA-CPSA-CHILD PROT SVC ACCEPTANCE
(4)Referred From : LCH

1 2 3 4 5 6 7
12345678901234567890123456789012345678901234567890123456789012345678901234

12/06/2009 -1830 MSW received phone call from Shandra Tyler, DSS York Cty, Ms. Tyler will be coming to the hospital to do an assessment. MSW will notify Sherry Deedrick, MSW ED SW. MSW d/w Sara, RN who has the pt, Sara does not feel parents are a flight risk and will let parents know that tho DSS worker is coming out to meet c the parents. MSW will follow as needed. For any questions this evening, please contact Sherry Deedrick, ED MSW at p 11436.

Katie Harrison, MSW p 6703

Edit Notes (Y/N)?--

CMC (12.05.09) 0095

Carolinas Patient Care Discharge Planning Processor
Sun Dec 06, 2009 05:36 pm

Account No	Name	Unit Number	Birthdate
09339-00393	[redacted] OWEN [redacted]	000545-02-19	[redacted]

(1)Date : 12/06/09
(2)Init : KAH
(3)Planning Code : CPSI-CPSI-CHILD PROT SVC INITIAL REFER
(4)Referred From : LCH

```
          1         2         3         4         5         6         7
1234567890123456789012345678902345678901234567890123456789012345678901234
01|12/06/2009 MSW note continued...dad noted that pt was sleeping more than
02|usual, woke up crying, then "stretched out, went limp but was still
03|breathing." Dad took baby to Piedmont Hospital, baby was limp during the
04|ride there, wimpered a little, did not open his eyes and when he handed
05|the baby to the nurse at Piedmont, baby screamed. Baby was evaluated at
06|Piedmont and was transferred to LCH early Saturday morning. Parents are
07|aware that a full body x-ray was done and that pt has "blood on the right
08|side of his brain." Parents deny any trauma, that anyone droppod the baby.
09|pt's birth was normal, full-term. Baby is only watched by parents and
10|maternal grandmother, no daycare. Baby is bottle fed. MSW contacted York
11|DSS after hours 803-628-3056 and received a call from on-call DSS worker
12|Shandra Taylor who took the report and will call MSW back. (MSW note conti
Edit Notes (Y/N)?--
```

CMC (12.05.09) 0097

Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 05:30 pm

Account No	Name	Unit Number	Birthdate
09339-00393	[redacted], OWEN [redacted]	000545-02-19	[redacted]

(1)Date : 12/06/09
(2)Init : KAH
(3)Planning Code : CPSI-CPSI-CHILD PROT SVC INITIAL REFER
(4)Referred From : LCH

```
          1         2         3         4         5         6         7
1234567890123456789012345678901234567890123456789012345678901234567890123456789012345678901234
01 1206/2009 ~1500 MSW received page re r/o NAT, work-up is negative for NAT
02 but pt does have a small subdural hematoma. Sara, RN reports that parents
03 have been appropriate, grandparents have been visiting. MSW met c parents,
04 mom is Kayla Lythgoe, dad is Michael Carduff, baby lives c both parents.
05 Baby lives at [redacted], Rock Hill, SC 29732, parents do not
06 have a home phone, only a cell phone c texting, [redacted], phone #
07 listed on demographic sheet belongs to MGM Charlotte Williams [redacted]
08 Pt's parents report that on Weds. 12/02/2009, parents noticed that baby
09 "not seeming like himself, sleepy more than usual" "screaming non-stop"
10 "funky smell out of his mouth" took the baby to Sunshine Pediatrics, to
11 see Dr. Paxton, who told the parents that it was a viral infection and to
12 give the baby Tylenol every 6 hours. On Friday night 12/04/2009 (note con,
Edit Notes (Y/N)?--
```

CMC (12.05.09) 0098

Carolinas Patient Care Discharge Planning Processor

Mon Dec 07, 2009 12:03 pm

Account No 09339-00393 | Name [redacted], OWEN [redacted] | Unit Number 000545-02-19 | Birthdate [redacted]

(1) Date : 12/07/09
(2) Init : LHN
(3) Planning Code : ASES-ASSESSMENT - INITIAL
(4) Referred From : LCH

```
        1         2         3         4         5         6         7
12345678901234567890123456789012345678901234567890123456789012345678901234
01 Met c parents at bedside to confirm DSS visit.  Met c worker from york co.
02 12/6 and signed safety plan, anticipate d/c hopefully this date.  Owen
03 lives c parents, no other children, does have Medicaid, WIC,
04 transportation, frequent babysitting c mat g'mother.  Both parents
05 employed, father has finished 10th grade, mother 11th, MSW discussed safe
06 sleeping, other parenting education available for parents prior to d/c.
07 Parents c questions about DSS investigation, MSW explained that DSS will
08 complete home visits upon d/c, will assist c medical follow up if needed.
09 No other questions, will follow for safe d/c plan.  Updated RN, MD.
10
11 Laura Newmark, MSW 5872d                                        MSW
12 12/7/09  1030
```

P1 Delete Line | P2 Insert Line | P3 Center | P4 Exit | P5 Store Line | P6 Restore Line | P7 Pack | P10 Help

CMC (12.05.09) 0094

Carolinas Patient Care Discharge Planning Processor
Mon Dec 07, 2009 12:07 pm

Account No 09339-00393 | Name [redacted], OWEN [redacted] | Unit Number 000545-02-19 | Birthdate [redacted]

(1)Date : 12/07/09
(2)Init : LHN
(3)Planning Code : CPSU-CPSU-CHILD PROT SVC UPDATE
(4)Referred From : LCH

1 2 3 4 5 6 7
1234567890123456789012345678901234567890123456789012345678901234

01 MSW spoke c worker Christa Hinnant 803-684-8154 re. patient condition, NAT
02 workup. Optho (-), NAT series (-), no other obvious signs of abuse,
03 neglect. MSW spoke c attending Dr. Courtlandt re. likely inability to
04 confirm NAT d/t limited findings, would like to have ongoing DSS
05 involvement c investigation, home visit, parenting education, f/u NAT
06 series in two weeks as outpt. Owen to have repeat CT scan today, no clear
07 d/c date. DSS to staff c attorney, but likely will allow d/c home c
08 parents. Child Maltreatment Coordinator has seen child as well, Nsg
09 following. Updated RN Tracey. Will follow.
10
11 Laura Newmark, MSW 58788 MSW
12 12/7/09 1200

F1 Delete Line F2 Insert Line F3 Center F4 Exit F5 Store Line F6 Restore Line F7 Pack F10 Help

CMC (12.05.09) 0093

EXHIBIT

"9"

Piedmont Medical Center - Rock Hill, SC 29732

Patient:	C[redacted], OWEN [redacted]	**DOB:**	[redacted]
MR #:	000345331	**Age/Gender:**	12w M
DOS:	12/4/2009 17:12	**Acct #:**	[redacted]
Private Phys:	Sunshine Pediatrics	**ED Phys:**	Christopher DiOrio, DO

Past Medical/Surgical History
Amendments to history obtained earlier:
FT/SVD at no pre, peri or post natal complications
"throat infection" diagnosed by Pediatrician Dr paxtor

Daycare none, no smokers in housem first child <CD3 12/04/09 19:34>
No significant medical history. <RS 12/04/09 18:54>
No significant surgical history. <RS 12/04/09 18:54>

Past Social History
Patient does not use drugs. <RS 12/04/09 18:54>
Patient does not use alcohol. <RS 12/04/09 18:54>
Patient does not use tobacco. <RS 12/04/09 18:54>

HISTORY OF PRESENT ILLNESS

Note
Medical Screening examination has been initiated.

Notes: seen with mother and father and gmother <CD3 12/04/09 19:32>
Medical and surgical history obtained. <CD3 12/04/09 18:57>
Social history obtained. <CD3 12/04/09 18:57>
Past family history obtained. <CD3 12/04/09 18:57>
HPI: A12 week old white male presents with "lethargic, not responsive and we thought he was dead."
Per mother and more specifically father who is with the child at the time of the incident, the patient was nonresponsive but still breathing and had good pulses and no cyanosis for a period of 5 to 10 minutes. Father states that the child got tense and quite possibly had a tonic episode with no clonic activity and subsequently was not arousable to gentle shakes or further stimuli.
They state the child has been having a poor appetite, and mildly "lethargic" which they describe as less crying more irritable over the past 24 hours.

ROS: As documented in HPI. All other symptoms are negative.

PE:
GENERAL: well appearing; well nourished; in no apparent distress; non-toxic, this is a "great" looking child very healthy with a strong suckle on my gloved finger
HEAD: normocephalic; atraumatic
EYES: PERRL; EOM intact
ENT: normal nose; no rhinorrhea; mucous membranes moist; pharynx clear
NECK: supple; trachea midline; non-tender
CARDIAC: RRR; S1, S2; no appreciable murmurs, rubs or gallops
LUNGS: breath sounds clear and equal bilaterally; no appreciable wheezes, rales or rhonchi
ABDOMEN: soft; non-tender; non-distended; no appreciable organomegaly
bilateral descended testes with a circumcised penis

EXHIBIT 9 388

EXHIBIT

"10"

Name: Michael Carduff DOB: [redacted] Phone # _____

Address: [redacted] Phone # _____

RHSC

City: _____ State: _____ Zip: _____

YORK COUNTY SHERIFF'S OFFICE Incident Report No: _____

Voluntary Statement

VOLUNTARY STATEMENT

I, Michael Carduff, know and understand my rights. Having decided to answer questions at this time, I now make the following statement.

I DID NOT TELL anyone that I dropped Owen. I DIDN't want Kayla to Put me back out the house. I was Scared I didn't Know what to do I thought he was fine. the only other thing That I admit to is Sometime in the Past I would get frustrated with Owen's Crying and Pat him in the back hard.

The statement above, consisting of 3 page(s), is made of my own free will. No one has threatened me in any way or promised me special treatment to cause me to make this statement. I am signing my name in the space below to show that it is my statement and it is the truth.

Signed: Michael Carduff Date: 1-11-10 Time: 9:57p

Witness: Amanda P. Carter Page 3 of 3

YCSO, (09-2000) Form: Statement 1

EXHIBIT 10 390

EXHIBIT

"11"

Carduff was asked to describe his and Kayla's relationship and their interaction with Owen. He stated that he and Kayla want to get married someday. He stated that since Owen came along things have been a little stressed. He stated that he lost his job in December after missing too much work when Owen got sick and had to go to the hospital.

Carduff stated that since he lost his job he and Kayla have been arguing. He stated that she made him leave for a little while. He stated that he stayed with friend in Concord NC during that time. Carduff stated that he was able to move back in about 3 or 4 days ago.

Carduff stated that since he is not working he keeps Owen by himself while Kayla works. He stated the she usually goes in at about 3:00 in the afternoon and gets home sometime around 10:30 or 11:00 at night. Carduff stated that when it is just him and Owen, they watch TV or he might try to get Owen to move around in order to help his balance and strength. Carduff stated that Owen is a happy baby most of the time. He stated that he sleeps several times during the day and only gets up a few times at night. Carduff stated that sometimes when Owen is fussy, he will take him for a ride in the car which usually puts him to sleep.

Carduff was asked to detail his and Owens activities for this past Sunday which was the day before Owens injuries were discovered. He stated that Kayla took Owen to church in the morning. He stated that they just hung around the house until Kayla went to work at about 3:00 that afternoon. He stated that Owen was fine most of the day and evening. Carduff stated that Owen started getting fussy at about 10:00 in the evening. He stated that he put Owen in his car seat and then put him in the car and rode around for awhile trying to get Owen to fall asleep. He stated that he and Owen got back home at about midnight. He stated that Kayla was at home sitting on the coach. Carduff stated that Owen was asleep so he carried him into his bedroom and put him in his crib.

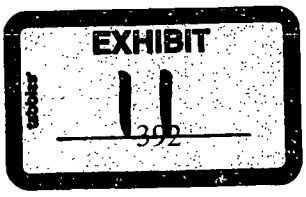
Carduff stated that Owen woke up twice during the night and both times he was the one that got up to check on Owen. He stated that Owen would not eat, but he appeared to be okay.

Carduff stated that Kayla got up to check on Owen at about 9:30 am and noticed that he was having seizures. He stated that they took Owen to the hospital in Rock Hill and that the doctors there decided that he needed to be flown to Charlotte.

The workings of the polygraph equipment and the testing procedure were explained to Carduff. The questions to be asked on the test were reviewed with him. Carduff was asked if needed to use the restroom and if he wanted a drink of water. He declined the water but did ask to use the restroom. He was escorted to the restroom by Det. Patterson and then back to the polygraph room.

The polygraph test started at approximately 20:10 hrs. and concluded at approximately 20:30 hrs. Carduffs responses to the test questions were indicative of deception.

It was explained to Carduff that he had failed the test and he was asked to explain again how Owen had been injured. Carduff began to cry and stated that he had accidently dropped Owen while carrying him down the steps this past Sunday night while Kayla was at work. He stated that Owen was strapped in his car seat when this happened and that he was going to take Owen for a ride to help him go to sleep. Carduff stated that Owen was very upset and crying after he was dropped. Carduff stated that he went ahead and put him in the car and tried to calm him down by talking to him. He stated that he rode around with Owen until he stopped crying.



EXHIBIT

"12"

Interview with Michael P. Carduff

January 11th, 2010

Moss Justice Center

Det. Doug Patterson

On January 11th, 2010, Michael Carduff reported to the Moss Justice Center to voluntarily take a polygraph examination. The polygraph was in reference to Carduffs four month old son, Owen, who had sustained head injuries that were consistent with Shaken Baby Syndrome. Carduff, his son, and girlfriend Kayla, live on Gauldens Park Rd. in York County. The polygraph was requested by Lt. W. J. Miller with the York County Sheriff's Office. The case agent on this case was Det. Amanda Carter. The polygraph was to be conducted by Det. Doug Patterson.

Det. Carter escorted Carduff to the polygraph room at approximately 18:50 hrs.

Det. Patterson introduced himself to Carduff as a law enforcement officer. Carduff was provided a form containing the Miranda warning. The rights portion of that form was read to Carduff. He acknowledged verbally and in writing that he understood his rights. Carduff was asked to read, out loud, the waiver portion of the form, he did so with no problem. He acknowledged verbally and in writing that he understood the waiver and that he was willing to talk to police and answer questions.

Carduff was provided a form containing the Consent To Interview With Polygraph. The rights portion of that form was read to Carduff. He acknowledged verbally that he understood his rights. Carduff was asked to read, out loud, the waiver portion of the form, he did so with no problem. He acknowledged verbally and in writing that he understood the waiver and that he agreed to the use of the polygraph.

The extent of Owens injuries as known to Det. Patterson were discussed with Carduff. He was asked if he did anything to cause Owens injuries, he replied no. He was asked if he knew who had caused Owens injuries, he replied no. Carduff did state that he and his wife had discussed Owens injuries in private and they did not have any idea how Owen was injured. Carduff was asked if understood that Owens injuries could not have just happened, that someone had to have did something to Owen to cause the injuries, he replied that he knew that was true.

A pre-polygraph work sheet was completed on Carduff. He is an 18 year old white male. He reported that he finished the 11th grade. He reported that he has been unemployed since about the middle of December 2009. Carduff stated that he and his girlfriend Kayla have been together for about 2 years, they have lived together for about a year. Carduff reported that Owen is his and Kayla's only child. Carduff reported that he is in good health. He reported that he is taking an antibiotic due to having a tooth pulled about a week ago. He reported that his mouth does not bother him at all. He reported that he does not do any kind of illegal drugs or drank alcoholic beverages. Carduff reported that he was charged with possession of stolen goods when he was 16 years old. He reported that he has no other criminal activity in his past.

EXHIBIT 12

Carduff was asked to describe his and Kayla's relationship and their interaction with Owen. He stated that he and Kayla want to get married someday. He stated that since Owen came along things have been a little stressed. He stated that he lost his job in December after missing too much work when Owen got sick and had to go to the hospital.

Carduff stated that since he lost his job he and Kayla have been arguing. He stated that she made him leave for a little while. He stated that he stayed with friend in Concord NC during that time. Carduff stated that he was able to move back in about 3 or 4 days ago.

Carduff stated that since he is not working he keeps Owen by himself while Kayla works. He stated the she usually goes in at about 3:00 in the afternoon and gets home sometime around 10:30 or 11:00 at night. Carduff stated that when it is just him and Owen, they watch TV or he might try to get Owen to move around in order to help his balance and strength. Carduff stated that Owen is a happy baby most of the time. He stated that he sleeps several times during the day and only gets up a few times at night. Carduff stated that sometimes when Owen is fussy, he will take him for a ride in the car which usually puts him to sleep.

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EXHIBIT

"13"

Clinical Member of
SCPA, SCALP, SCAPP
APA, ACFE

Area of Specialty:
Counseling Psychology,
APA Division #17

J. Patrick Goldsmith, Ed.D.
PSYCHOLOGICAL ASSOCIATES, P.A.
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Telephone/Facsimile (803) 283-4004

STATE OF SOUTH CAROLINA COUNTY OF YORK	IN THE FAMILY COURT SIXTEENTH JUDICIAL CIRCUIT
South Carolina Department of Social Services, Plaintiff, versus Michael Carduff, Kayla Lythgoe; Charlotte Williams and Larry Williams, Defendants. In the Interest of: Owen [redacted], DOB: [redacted] A Minor Under the Age of 18.	REPORT OF PSYCHOLOGICAL EVALUATION File Book #10-DR-46-314

EVALUATED:

April 19, 2010 19 year-old mother Kayla Lythgoe DOB: [redacted]

REFERRAL INFORMATION:

This nineteen year, ten month-old single, Caucasian female was referred for psychological evaluation by Arinette Y. Dye, Human Services Specialist II with the York County office of South Carolina Department of Social Services. One of numerous Recommendations to be submitted to the court by that agency was that Ms. Lythgoe complete a psychological evaluation "and comply with the recommended treatment resulting from the evaluation". Guardian *ad Litem* Lauren McCauley also requested that a psychological evaluation be completed, the purpose being "to determine whether or not she has the maturity and intellectual comprehension to care for a child with the severe and complex needs that Owen now has".

DSS-YS 0070

EXHIBIT
Stoker 13

INFORMATION REVIEWED:

DSS forwarded roughly an inch and-a-half of and records pertaining to this case. Included were:

[redacted] 2009	medical records re: birth of Owen C[redacted] Piedmont Medical Center, Rock Hill, South Carolina
December 4-5, 2009	medical records from treatment of Owen at Piedmont Medical Center
January 11, 2010	medical records from treatment of Owen at Piedmont Medical Center
January 11, 2010	Affidavit and Arrest Warrant of Michael Patrick Carduff: J-169399, Children/Unlawful Conduct Toward A Child, signed by Judge Leon E. Yard
January 11-20, 2010	Transfer Summary of treatment at Pediatric Intensive Care Unit, Levine Children's Hospital, Carolinas Medical Center, Charlotte, North Carolina
January 20-26, 2010	records of services rendered at Hospice & Community Care, Rock Hill
(no date given)	(2) articles from *The Herald* re: Owen [redacted]
February 10-17	records re: treatment at Carolinas Rehabilitation, Levine Hospital
February 17, 2010	Affidavit of Imminent And Substantial Danger and Affidavit of Reasonable Efforts *Ex-parte* Removal, each signed by Diva Hemphill, Human Services Specialist, South Carolina Department of Social Services, York County office
February 17, 2010	Complaint for *Ex-parte* Removal filed by David E. Simpson, Attorney for Plaintiff, S.C. DSS
February 17, 2010	*Ex-parte* Order of Removal signed by The Honorable Henry T. Woods
March 13, 2010	Special Conditions of Bond Order, Case No.: J-155212, Inflicting Great Bodily Harm Upon A Child, State of South Carolina vs. Michael Patrick Carduff, signed by The Honorable Clayburn S. Burnette, Junior, Bond Court
(undated, unsigned)	S.C. DSS Court Information Sheet/Supplemental Report prepared for 35-Day Removal (Merits) Hearing
c. March 16, 2010	S.C. Guardian *ad Litem* Program Report and Recommendations of the Volunteer GAL, Lauren McCauley
April 22, 2010	telephone consultation with Annette Dye, HSS II, York County DSS

CASE HISTORY:

Charlotte (DOB: [redacted] and Larry Williams (DOB: [redacted] are the mother and stepfather of Kayla Lythgoe. The couple lives in Rock Hill, S.C., where Mr. Williams is Senior Pastor at Family Faith Christian Center.

Kayla Lythgoe resided with her paramour, Michael Patrick Carduff (DOB: [redacted]. On [redacted], eighteen year-old Ms. Lythgoe was induced at Piedmont Medical Center and vaginally delivered at forty weeks gestation Owen [redacted], son of nineteen year-old Mr. Carduff. Because she had untreated Group B Strep, Owen spent two days in Neonatal ICU. Mother and son breastfed well, and Owen was to nurse at least every two hours, which would help with jaundice. Owen passed hearing screenings for both ears before being discharged home on September 11.

The Lythgoe-Carduff family resided at [redacted] in Rock Hill, within walking distance of the Williams. The Williams were very active in the care of Owen and frequently babysat. Sitters were only occasionally used, and Mrs. Williams provided childcare for Owen during the day.

On December 4, three month-old Owen was taken to PMC "unresponsive and lethargic". After evaluation, he was transferred to the Pediatric Intensive Care Unit of Levine Children's Hospital. There, Owen was found to have two subdural hematomas, cause unknown. He was diagnosed with an acute, life-threatening event, rule out non-accidental trauma, and thus on December 6, DSS was notified and became involved. Levine's social worker reported no obvious signs of abuse or neglect, and Levine mostly had concerns for lack of supervision. On December 8, Owen was discharged home to his parents with instructions to take special care of him, note and report any changes in his condition and immediately seek medical care if anything unusual occurred at all with him. Owen was to return in two weeks for repeat skeletal survey; his parents were to pay close attention to him, not leave him alone or unattended and monitor for changes in mental status, increased lethargy, and onset of vomiting. DSS advised parenting classes and a home evaluation upon discharge.

On Friday, January 9, 2010, Ms. Lythgoe saw a bruise on four month-old Owen's forehead, but told no one and sought no medical attention or follow up. That Saturday and Sunday (10th and 11th), she went to work and Mr. Carduff kept Owen. Mr. Carduff admitted that on the night of January 10 or on the 11th, he physically shook Owen "out of frustration" and did not notify anyone or seek medical treatment. January 11, after Owen began jerking and shaking uncontrollably, he took him to PMC. Owen was seizing upon arrival and found to have multiple acute subdural hematomas and multiple bruises on his chest, arms, cheek and legs. Upon inquiry, his mother stated an old, brownish bruise on his upper chest was from "scratching himself". Rock Hill Police were notified for possible abuse and arrived to investigate before Owen was airlifted to Levine's PICU on that same date.

Asked at Owen's January 11 admission to Levine about his chest bruise, his parents stated he "must have scratched himself". Mrs. Williams told staff she had seen a "goose egg" on the middle of Owen's forehead on January 9; she had asked Mr. Carduff it had occurred, and he told her Owen "must have scratched himself". Per Case Manager Dye, when he was admitted, Ms. Lythgoe stated that she was returning to Rock Hill to get clothing and was gone several hours. Law Enforcement reported she instead drove to Moss Justice to be with Mr. Carduff while he underwent a polygraph.

On January 11, Mr. Carduff was arrested and charged with Unlawful Conduct Toward A Child.

According to Annette Dye, Levine expressed concern that Ms. Lythgoe had no bond with Owen and "showed no emotion with him". Owen was in critical condition for several days. He seized throughout January 11 and 12 and was found to have bilateral retinal hemorrhages and acute on chronic non-accidental traumatic brain injury with associated neurological deficits. Mrs. Williams informed *The Herald*, to whom she provided at least two interviews, that he could not move, eat or drink. She stated doctors said tests showed 70% of his brain was damaged and he was so badly injured, "if we chose to keep him alive, the doctors told us Owen would basically be a vegetable". On January 15, the family requested DNR status. When Owen showed increased spontaneous movements on his January 16 exam, family rescinded the DNR. Consulted on January 18 regarding his 1/16 MRI results, Neuroradiology agreed Owen's prognosis was very poor, and on that date, Ms. Lythgoe and the Williams agreed to again withdraw support and make Owen DNR/DNI. After extubation, he breathed independently. On the 19th, Ms. Lythgoe requested withdrawal of all care, including fluid and nutritional supplementation. She also decided to transfer Owen to a hospice.

On January 20, Ms. Lythgoe and the Williams took Owen to Wayne T. Patrick Hospice House in Rock Hill. Owen was the first baby Hospice House had cared for. He was given Morphine for pain. According to attending MD Amy Robbins, after twenty-four hours there, Owen began making a sucking motion, which he had not done since his injury. The family decided to give him nutrition - Pedialyte and formula. Owen began acting more like a normal baby, even crying and fussing if he had a messy diaper. On January 22, Owen took a bottle, the family rescinded his DNR and asked that it be destroyed, and plans were initiated to transfer Owen to a rehabilitation facility/center.

On January 25, the Williams drove Owen back to Levine. Simple, normal four month-old tasks had to be relearned, and Owen underwent daily physical therapy and staff worked with him on motor skills and coordination. All of Ms. Lythgoe's visitation was to be supervised by her mother. On January 27, DSS received a report that while in Ms. Lythgoe's presence, Mrs. Williams was rocking and feeding Owen. She lost her balance, the chair fell out from under her and she fell on the floor. Owen, who was on her shoulder, hit his head against the wall, leaving a red mark. Staff believed "the story does seem a bit odd". Consequently, mother and grandmother's visitation with Owen was to be supervised 24/7. On the 28th, both grandparents requested Owen be discharged soon so they could continue therapy at their home; Dr. Wunderlich examined Owen with a resident; and both had "concerns with family's ability to provide a safe discharge for Owen at this point in time". Dr. Wunderlich's 29th note reads: "At this time, I have concerns with return to maternal grandmother's home secondary to the incident. I believe foster family placement would be a safer option."

Per hospital records, at some point, visitation by both Mr. and Mrs. Williams was required to be supervised 24/7. Per *The Herald*, they started the Owen C[redacted] Foundation to help raise money for Owen's rehabilitation, raise awareness of Shaken Baby Syndrome and educate other teen parents.

On February 4, DSS indicated both of Owen's parents for Physical Abuse. They also recommended their placement on the Statewide Central Registry of Child Abuse and Neglect. Also that month, The Honorable Henry T. Woods presided at a closed hearing regarding how Owen should be fed. Ms. Lythgoe wanted him to be able to survive without invasive measures, such as a gastrostomy tube, and stated she felt that "if he could do it on his own, then it was 'God's will' for him to live". While Levine worked with Ms. Lythgoe to return Owen to her care, she became very distraught and stated she did not think she would be able to care for him. DSS noted she had failed twice to keep Owen safe from violence that caused acute and chronic brain injuries from non-accidental trauma and did not demonstrate capacity, ability or judgment to safely care for him on an inpatient unit. The only relative she agreed to for placement was her mother, who was excluded due to her criminal record. Thus, on February 17, DSS filed a Complaint and received custody via an *Ex-parte* Order.

On February 17, Levine wrote that referrals had been made to BabyNet, Interim Home Health and Advanced Home Health. Nutrition was to be supplied by WIC, which Ms. Lythgoe was to recertify. The letter delineated numerous services, visits, meetings, training and care necessary for Owen.

On February 18, less than a month after life support was ceased, Levine discharged Owen. Mrs. Williams' incident with the rocker led to her care of Owen being questioned and her visitation being prohibited as of February 18. Owen was placed in a therapeutic foster home in Lancaster County. The foster mother, a Licensed Practical Nurse, works weekends. One parent is always present, and their eleven and fourteen year-old daughters are in the home. Owen has mobility, sight and hearing impairments, permanency as yet unknown, and receives on-site speech, occupational and physical therapy. He has a gastrostomy tube for intermittent feedings, takes medications to control seizure activity and needs early intervention, many medical procedures and close observation at all times. Medical providers have are uncertain whether he will be blind or paralyzed for the rest of his life.

The Special Conditions of Bond Order, signed March 13, shows Mr. Carduff charged with Inflicting Great Bodily Harm Upon A Child and restrained from any contact with Ms. Lythgoe and Owen. He was denied bond and remains incarcerated at Moss Justice Center.

Law enforcement has not charged Ms. Lythgoe. She wants custody of Owen. She has a full-time job and housing and has cooperated with DSS. She goes to Owen's foster home for all visitation, which must be supervised, and joins his foster parents on his appointments.

Mr. and Mrs. Williams appear to have significant influence on Ms. Lythgoe, and she continually shifted care of Owen and all of her medical decisions to her mother. Guardian *ad Litem* McCauley wrote, "Having observed an interaction with Kayla and her mother at a Treatment Plan Meeting, where Owen was brought by the foster parents, I have concerns about their comprehension of the physical needs of this baby....The gastrostomy tube concerns them. They appear afraid of it. Kayla did not keep herself abreast of paperwork for Owen and his Medicaid was terminated. **I believe it will take intense training and a maturity that has not been demonstrated by Kayla to be able to manage the day to day care of Owen.** She has to support herself, which requires her to work and Owen should not go to a daycare setting. Mrs. Williams does not meet the requirements to be awarded custody of Owen due to a charge that was brought against her, less than 5 years ago. She would like to take care of Owen as well, but the rocking chair incident, although accidental, is an example of the lack of understanding of how inattention to detail could be detrimental to Owen's well being."

CLINICAL INTERVIEW AND BEHAVIORAL OBSERVATIONS:

Ms. Lythgoe was accompanied to the office by her mother, Charlotte Williams, and arrived on time for her evaluation appointment. She was sensibly and comfortably attired for the occasion.

Ms. Lythgoe was oriented to time, place and person. She denied any current problems or difficulties with headaches, dizziness, blurred vision, anxiety, depression, hallucinations, nightmares, sleep onset and sleep interruption. She stated she is maintained on no medication. She stated that she has never seen a psychologist, psychiatrist or mental health worker, and made it very clear that she does not believe that she needs to.

According to Ms. Lythgoe, she took her first drink at age sixteen. She reported her maximum tolerance within a twenty-four hour interval is two beers. She stated she typically does not consume alcohol, and her most recent use was at age sixteen. As concerns use of any illegal or non-prescribed drugs, she stated that she has used Marijuana on one occasion.

Ms. Lythgoe reported that she completed tenth grade. During eleventh grade, she quit school. She stated she had been maintaining a long-distance relationship with Mike Carduff, and went to live with him and his parents in Concord "because I had a bad home life".

At the present time, Ms. Lythgoe continues to reside at [redacted] in Rock Hill, S.C.. She reported that as of this July, she will have been employed with Walgreen's for two years.

When I had inquired of Ms. Lythgoe regarding her understanding of why she was here, she replied simply, "Procedure". Asked what she meant by that, she responded, "If I'm still fit after all I have been through". As there appeared to be a good deal of denial in regard to the seriousness of her present circumstances, I asked if there were any charges against her. She finally responded, "Yes. Neglect." I asked what that meant, and she replied, "I don't really think it was neglect."

Michael Carduff, father of Owen, stands charged with Unlawful Contact Toward A Child and has admitted shaking their infant out of frustration. I inquired regarding their relationship. Ms. Lythgoe stated she and Mr. Carduff have been together two years and never married "because of money". She indicated they engaged in verbal arguments about once every two weeks and had never had a physical altercation. She stated Mr. Carduff had never used alcohol or drugs and was "against it". She added, "He played videos too much and wouldn't go to bed with me". As concerns employment, she stated he began working at Food Lion in February of 2009, but in December had simply "stopped going". She stated there is "no chance" of them reconciling.

Ms. Lythgoe stated that seven month-old Owen has been in foster care since February. I inquired regarding Mr. Carduff's relationship with their infant. Ms. Lythgoe responded that when Owen cried, "I checked for the basics: diaper, feeding, rocking him to sleep. At times, I left the room until he 'cried it out'." As she had not answered regarding Mr. Carduff, I inquired again. Ms. Lythgoe responded, "He did the same". I asked whether Mr. Carduff ever became frustrated. She replied, "When he did, he would give the child to me". She spontaneously added, "I had kicked him out because he quit his job New Year's Eve, and I told him that he could not come back 'until you're not such a bum and play video games all day'." She evidenced no insight into the fact that she allowed him to return before he secured a job, and my belief is that he was still exhibiting the same irresponsible behavior.

I asked Ms. Lythgoe if she believed Mr. Carduff had injured Owen on more than one occasion. She replied, "I do believe it happened one time. No; something happened in December. In December, Owen was taken to the hospital, passed out and bleeding in his brain. I was never told that it was Shaken Baby Syndrome. In January, it happened again. DSS was involved both times, and after the first one, they suggested parenting classes". She could offer no rational explanation as to why she had not sought medical attention after she saw the bruise on Owen's head on January 9 or how he sustained the multiple bodily bruises documented when he arrived at the hospital the next day.

Asked whether she could remember all of her early childhood, Ms. Lythgoe replied, "Yes!" Her account is remarkable. Her mother has married thrice, and she has one sibling, a brother. Her mother supervised an apartment complex and her father was employed in Maintenance. Her father physically abused her mother weekly, and she described him as "mean, careless and stupid". She stated the worst of his abuse she witnessed "was him punching her in the face". She indicated that on many occasions, she wondered why her mother remained in the marriage, considering the abuse her father inflicted. When asked whether her father was an alcoholic, Ms. Lythgoe indicated that he drank, but did not address the question of alcoholism. Upon further inquiry, she did state that he typically consumed a six-pack of beer a day, which certainly satisfies criteria for addiction. When Ms. Lythgoe was eleven years old, her parents divorced. Her mother next married a "native, isolative and quiet" man who neglected and verbally abused "mom, not me", weekly. She denied any use of alcohol or drugs on his part. When Ms. Lythgoe was seventeen, her mother divorced again, and when she was nineteen, her remarried again. Ms. Lythgoe denied any sexual or physical abuse of herself and any nightmares during childhood. Asked again whether she felt that she had any problems or issues that needed to be addressed in therapy, she replied, "No!"

I inquired regarding what Ms. Lythgoe knew about Mr. Carduff's childhood and whether there had been any abuse. Her description of his childhood was idyllic. She stated his parents have an intact marriage and are both employed. Although Mike had two siblings, "he is the favorite of his mom, and he gets whatever he wants". He was raised in Florida, and "went to Disney World all the time". As a child, he was "into racing go-carts". When he was sixteen years old, the family moved to Concord. Mike's parents bought him a car for his birthday, constantly gave him money and when she lived with Mike in their home, there was no rent. She stated Mike's twenty year-old brother has never worked and still resides with his parents.

TESTS ADMINISTERED:

Bender Visual Motor Gestalt Test
Wide Range Achievement Test - Fourth Edition (WRAT4) (blue form)
Rotter Incomplete Sentences Blank (RISB) - Adult Form
Human Figure Drawing - Draw A Person (DAP)
Minnesota Multiphasic Personality Inventory - 2 (MMPI-2)

Ms. Lythgoe's *Bender Visual Motor Gestalt Test* reproduction indicated no significant perceptual motor pgvbroblems.

Achievement testing, utilizing the *Wide Range Achievement Test-Fourth Edition*, yielded the following scores and equivalencies:

SUBTEST/COMPOSITE	RAW SCORE	STAND. SCORE	CONFIDENCE INTERVAL (95%)	%ILE RANK	NORMAL CURVE EQUIV'T	STANINE	GRADE EQUIV'T	PERFORMANCE LEVEL
Word Reading	50	82	74-91	12th	25	3rd	6.9	below average, low
Sentence Comprehension								
Spelling								
Math Computation	36	85	76-96	16th	29	3rd	6.1	below average
Reading Composite								

The three point difference between Reading and Math Subtest Standard Scores was not at a sufficient level of statistical significance or prevalence in the standardization sample to warrant further investigation.

Significant responses Ms. Lythgoe provided to *Incomplete Sentences Blank* prompts follow, with no corrections to spelling or grammar:

I want to know why some things have to happen.
Back home when I was a Kid, things were esier [sic].
I regret not paying more attention
Men are confusing
The best thing about me is my personality.
A mother's love is the Strongest, most real love ever!
I feel fine
My greatest fear is being alone.
I can't wait to get my son Owen back!
My nerves are strong
I suffer when I get cut off from my family and friends.
I failed with finishing school.
My mind is full of thoughts.
I need to move, I fidget a lot [sic]. Always have.
Marriage is something I look forward to.
What pains me is to see people treated unfairly.
This pace is boring.
I am very upbeat.
The only trouble I have with myself is weight loss.
I wish that I could have finished School.
My father is dead to me.
I secretly want to live with my mom forever.
My greatest worry is never getting Owen back.
Most women are smart!

Ms. Lythgoe's *Minnesota Multiphasic Personality Inventory-2* produced a valid profile. These patients tend to be somewhat defensive. They are probably reluctant to admit problems in some areas, but willing to admit problems in other areas. Further interpretation of Ms. Lythgoe's *MMPI-2*, with changes based on results of her clinical interview and projective testing, follows:

These are typically gregarious, outgoing, sociable individuals with good social techniques. Although they need to be with others, relationships are apt to be superficial and insincere. They tend to overreact to social stimuli and be argumentative and may provoke resentment and hostility in others. Others may see them as difficult to deal with, over-reactive and prone to misperceive social stimuli. They may also be perceived as aloof and uninvolved.

Such scores indicate a verbally expressive individual who may under-control emotions. Prominent feelings probably include hostility and resentment, and family members are likely to be the focus of at least a part of these feelings. Feelings may be directly stated or expressed passive-aggressively.

Such scores may indicate a competitive, flighty, immature, opportunistic, verbally fluent individual. Exhibitionism and self-indulgence can be present. Difficulty delaying gratification and impulse control problems are possible. These people may be guarded, stubborn and touchy and overreact to criticism. Paranoid traits may include over-sensitivity and rigidity.

Similar people may think differently and have unique views about the world. Their thoughts may be creative, avant-garde and imaginative, but excessive daydreaming and avoidance of reality through fantasy are possible. Abstract interests and neglect of people and practical matters are conceivable. They can be self-critical and dissatisfied and worry about minor problems and meeting responsibilities. Feelings of being mistreated and suspiciousness may be apparent. These patients can hold on to minor hurts, harbor grudges, blame others for problems and emphasize their rational side. Projection, rationalization and intellectualization may be used excessively. Schizoid processes may be present. A thought disorder and paranoid features are possible.

These patients will not like to discuss their problems. Rapport may be difficult to establish, and this could be due to their suspiciousness and oversensitivity. Others may be seen as the cause of problems. Early termination of therapy is typical. Prognostic indication is poor.

DSM-IV DIAGNOSTIC IMPRESSION:

AXIS I:	309.4	Adjustment Disorder With Mixed Disturbance of Emotions And Conduct
AXIS II:	301.6	Dependent Personality Disorder
AXIS IV:		Severe Stressors due to DSS and legal involvement

CLINICAL FINDINGS AND CONCLUSIONS:

Even though I am not at all sure that there is not more Ms. Lythgoe could have reported regarding her childhood, many of her present issues appear to have originated in her family of origin, which she indicated she attempted to escape when she moved out of her home and in with Mr. Carduff and his family. Medical University of South Carolina's Criminal Violence Research Center indicates that witnessing abuse of a significant other during formative years often creates the physiological reaction of Posttraumatic Stress Disorder, and this may well have resulted in "hysterical blindness" in regard to Mr. Carduff.

Ms. Lythgoe clearly has no insight in regard to her issues, which are important for her to understand. Her long-standing defense mechanisms serve to protect her from identifying her own role in matters, as well as her finding of Neglect. She very much tended to deny and minimize problems in her and paramour's relationship. She does not understand the irresponsibility of her father and same irresponsibility in Mr. Carduff. In all likelihood, her tremendous blindside in regard to men is modeled after her mother. She very well may also be emotionally enmeshed with and excessively dependent on her mother due to a trauma bond.

Whether Ms. Lythgoe reconciles with Mr. Carduff or not, she still poses a threat to Owen until she understands her issues and failure to protect. At this time, she has no understanding of these and does not believe neglect was involved.

One Clinical Scale on Ms. Lythgoe's *MMPI-2* fell within hospitalized psychiatric range. Records convey when Owen was inpatient at Levine's rehabilitation unit, she failed to demonstrate capacity, ability or judgment to safely care for him and became very distraught and said she did not think she would be able to care for him. Owen's Guardian expressed concerns about her and her mother's comprehension of Owen's physical needs and Ms. Lythgoe's maturity, failure to keep Owen's Medicaid current, and ability to manage his day-to-day care. Owen is a Special Needs child. All of these factors, in addition to Ms. Lythgoe's dependency and other unresolved issues, indicate a very poor prognosis for parenting.

Despite the fact that Ms. Lythgoe does not believe she has any problems and any need for therapy, her resolution of excessive dependency and issues with men is extremely important and best dealt with in therapy.

I would recommend that Mr. Carduff be evaluated and results of this evaluation be forwarded to his evaluator, as this information may have a bearing on his evaluation.

J. Patrick Goldsmith, Ed.D.
Licensed Counseling Psychologist, APA Division 17
South Carolina License #262
Fellow, American College of Forensic Examiners
Diplomate, American Board of Psychological Specialties,
Forensic Psychology

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reporter that Owen was doing well at Levine's Children's Hospital and the baby is no longer at Hospice-she informed the reporter they gave the baby some sugar water and the baby begin to suck the bottle and move. Detective Carter eventually came from the back and asked Case manager and Kayla to come to the back to the conference room. While in the conference room Detective Carter informed Kayla that she and case manager Hill wanted to follow up with her. Detective Carter and Case manager spoke with Kayla about the recent incident with Charlotte rocking Owen and flipping over in the rocking chair. Kayla said she was asleep on the couch when it happened. She said her mother was feeding Owen and the chair fell over and she got up from the noise of the chair. She said her mother did not go get the nurse because she was still in the rocking chair and Owen had bumped his head. Kayla informed both that her mother told her to get a nurse. When she came into the room her mother was already standing up and they did a CT scan on Owen-in which everything was fine with him. Incident that occurred with the shaking-Kayla said Sunday morning the family went to Church and Owen was fine and he did not have any bruises and nothing was wrong with him. She stated she went to her mother's home around 1-1:30pm she could not remember the exact time. She stated because she had to be at work at 2:30pm. She stated she left Owen with his father and around 10:30pm-he was not at home. She stated Michael usually take the baby for a drive however they did not come back for two hours. She stated she called and he told her that he was at McDonalds and Owen was sleep in his car seat. Kayla stated she glanced in at the baby that night however did not really check on the baby. She stated that morning the baby was crying and Michael told her that he will get the baby and she went to the restroom. She stated it was around 4am that morning. On Monday morning around 10 something-the baby was making noises and twitching-Michael was freaking out and she saw bruise on his chest-she thought that the baby may have scratched himself-they took the baby to Piedmont Medical Center because they were afraid it would take a long time for the ambulance to get to the home. Kayla talked about the baby having seizures and them transporting the baby to Levine's Children's Hospital. Case manager inquired about the scratches on his chest-she stated sometimes the baby pinches himself at night time. She stated there were no other marks/bruises on the child-she stated Owen scratched himself. December incident-Kayla stated she does not know what happened to the baby in December. Kayla stated she came home one day and Michael ran out the home holding Owen-Michael told her Owen was asleep for a long time and he woke Owen up to feed him however the baby would not eat and the baby woke up screaming and went limb. She stated they took the baby to the hospital. Case manager inquired about caregiver for the child-she stated that her mother Charlotte watched the baby all the time usually 5-6 times a week. She stated they were responsible when they watched the baby-she stated somebody always watched the baby. Case manager inquired again about any marks-including the mark that her mother observed on the baby's head in November-Kayla stated Michael said he hit himself with some keys (toy) it was on a Saturday and both she and her mother was upset about the incident. She was upset at her mother for asking her questions about the baby having scratches and marks when she did not know where they were coming from. Case manager inquired about any other marks and bruises-Kayla said no. Michael leaving the home-Kayla stated she and Michael had an argument and he left the home for about a week or four days she could not remember-she stated she kicked him our around New Years Eve and he came back on the 4th or 5th of January. She stated the argument was about him not being responsible and caring for the baby and not having a job in which he quit his job. Michael's interaction/concerns: Kayla stated Michael had not done anything to make her think that he had done anything wrong to the baby and he was never violent. She stated her mother never liked Michael because of the way he looked and he was a lazy kid and felt she could do better. She stated her mother Charlotte always disagreed with Michael. Case manager inquired about Investigation-Kayla stated she thought the investigation was closed. Case manager inquired about who told her that-she stated nobody-Case manager asked her about the conversation at the home and asked her about the booklet and brochure-she stated she remember it however she forgot all about it and did not think no more about it. She stated she felt if they were parenting classes she feel as though Michael would not have done what he done. Case manager asked her who told her about parenting classes-she stated the hospital told her then she later said DSS told her about the parenting classes. She stated she though it was over and it was closed and opened up again after the incident happened again. She stated her mother has been talking to the doctors and nurses and she don't know what is going on with Owen. She stated Case manager would need to talk to her mother about it. She stated she does not remember anything. Discipline-Kayla stated when the baby cries they usually try feeding, swing, holding and rocking the baby. She stated when she becomes frustrated she calls her mother to get the baby. Supervision/Caregivers: Case manager inquired about caregivers for the baby-Kayla mentioned her mother, Michael, and herself were the main people that watched the child. Case manager inquired about the paternal grandparents-Kayla stated they were never alone with the baby and the last time they seen the baby was for Christmas. She stated Brain would never be with the baby-she stated he was always with one of them.

Actions:

Staffing

EXHIBIT

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0001545398 - C[redacted] Owen - 09/09/2009 (E)

Action Date: 2/4/2010 **Action Time:** **Time Spent:** 2.25

Input Date: 2/9/2010 **Input Time:** 12:09 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:09:54 2/9/2010

Case staffed with Supervisor Hinnant, PC Ward, Attorney Simpson, Director Stewart, PC Wallace and CM Hill for case decision. See DSS Form 3062 in file.

Actions:

Face to Face with child/client

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)
0001545390 - Lythgoe, Kayla - 06/12/1990 (E)
0001545391 - Williams, Charlotte - 03/01/1969 (E)
0001545398 - C[redacted] Owen - 09/09/2009 (E)

Action Date: 2/4/2010 **Action Time:** **Time Spent:** 1.00

Input Date: 2/16/2010 **Input Time:** 12:19 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:19:53 2/16/2010

INVESTIGATIVE ASSESSMENT SUMMARY – SIX QUESTIONS: 1. Maltreatment: What is the extent of the maltreatment? R/S two month old male baby has two subdural hematoma(sizes 3mm and 2mm). R/S there is a Fatz Subdural Hematoma which raises the possibly of no accidental trauma. R/S parents behavior has been appropriate with the child. Baby is 2 months old-birthday [redacted] baby was initially admitted to Piedmont Medical on 12/4/09 and was transferred to CMC Main(Levine Hospital). R/S CT scan shows two subdural hematoma. No other children in the home. CM was informed of no physical /mental delinquency. Parents were observed to be appropriate and concerned. Parents took the baby for medical treatment on 11/28, 12/2 and 12/4. no mental/physical/spouse abuse known at this time. No known prior CPS history. Parents reside with maternal grandmother and they all are the primary caregiver of the child. Both parents are employed and live together, No known martial/financial problems or violence noted at this time. Interview with Kayla: Ms. Lythgoe said that they first noticed a change in Owen's behavior on 11/28/09. Ms. Carduff said that Owen was sleeping a lot and screamed when awake, non stop. Ms. Lythgoe said that they took Owen to Riverview 24hr Clinic that same evening that the doctor said nothing was wrong with him. Ms. Lythgoe said Owen continued this abnormal behavior throughout the week and on 12/1/09 went all day and night without urinating. (Mr. Carduff entered the room and sat by Ms. Lythgoe) Ms. Lythgoe

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said they scheduled an appt with his pediatrician for 12/2/09 at Sunshine Pediatrics with Dr. Paxtor. Ms. Lythgoe said that Dr. Paxtor said that Owen had a throat infection and a minor cold. Dr. Paxtor did not prescribe any medication. On 12/4/09 Ms. Lythgoe said she was pulling in the driveway and Michael came outside and said that Owen just went limp, but was still breathing and they rushed Owen to Piedmont Medical Center. Upon arriving at PMC, Ms. Lythgoe said Owen let out a loud scream and took a huge breath. Ms. Lythgoe said PMC transferred Owen to Levine Hospital on 12/5/09. Collateral Contact: Laura Newmark(Social Worker)She stated that she has talked with the pediatric staff and at this time the hospital cannot determine whether the injuries are accidental or nonaccidental. She stated that Owen's Eye Exam and Skeletal Survey were negative. She stated that they are going to repeat the CT scan today because Owen's head still appears swollen. She stated that the family has no clear history of trauma, however, the hospital still cannot rule out any trauma. She stated that they parents are too young parents and the hospital mostly has concerns for lack of supervision. She stated that it is unknown if Owen will be discharged today or tomorrow and that will be determined by the results of Owen's CT Scan. Laura stated at this point there are no obvious findings of abuse/neglect. FYI: owen is in the hospital, seizing, has an acute bleed in head, more that one bleed, multiple bruises chest, arm cheek, leg, detective carter at hospital, owen is actively seizing not a good sign, he is incubated icu on a ventilator, critical condition, parents and grandparents there, parents report no knowledge of injuries and bruises, much more serious this time the injuries. Mrs. Williams reported in November she observed the child to have a bruise on his head-she stated she took a picture of the bruise-Michael and Brian had the child and could not tell her how the child got the bruise on the child's head. The week prior to December 4, 2009 the child was crying a lot and the parents took the child to Sunshine Pediatrics and they informed the parents the child had a throat infection and it had gotten worse-child was taken to Riverview Medical Center and later taken to Piedmont Medical Center in which they performed test-Michael was watching the child when the baby went limb-Kayla had gotten off from work and Michael meet her at the door with the baby limb scratched out. Child was taken to Piedmont Medical Center then Levine's. It was determined the baby had bruising to the brain. Mrs. Williams stated there were no other incidents she could recall after wards until this weekend. Owen was at her home on Saturday and she observed looked like to be a scratch on the child's head-she placed the child in the light and observed a bruise about the size of a dime on the child's forehead. She stated she felt it and it was soft and full-she stated she observed the nurses and doctors last time checking the child like that. Michael was asked about the child's forehead in which he stated he did not know. He later stated the child sleeps in the crib by himself and he maybe hit his head on something. On Sunday, during child the child was sitting on Michael's lap and later placed in his carrier. When asked to hold the child-Michael would not allow her-When asked to have the child come to her home-Michael stated the baby was going home with them. 2. Nature: What surrounding circumstances accompany the maltreatment? Family did not have any prior DSS history 3. Child Functioning: How does the child function on a daily basis? Include pervasive behaviors, feelings, intellect, physical capacity and temperament. There is one minor child of the family. Owen was born September 9, 2009-child did not attend daycare-child was taken care of by his parents and grandmother Charlotte Williams. Child did not have any outside services. Owen received medical service from Sunshine Pediatrics, Piedmont Medical Center, Levine's Children's Hospital, and Riverview Medical Center. Owen is currently at Levine's Children's Hospital he recently received the G-tube surgery-he was having a hard time feeding and was not getting enough calories-family were in argument with the surgery however changed their mind-in the end Kayla signed the consent to have the surgery. 4. Parenting – Discipline: What are the disciplinary approaches used by the parent and under what circumstances? Parents stated during follow up they do not discipline the child-later it was discovered/disclosed that Michael shook the baby because the baby would not stop crying and he was frustrated with the baby-he stated when the baby cries they usually take the baby for a ride in the car or take the baby to the Williams' home. While in the hospital in January-Own had marks and bruises on his body. 5. Parenting – General: What are the overall, typical, pervasive parenting practices used by the parent? (Do not include discipline.) The family did not have any expectations for the baby-When there was a problem Kayla usually calls her mother and her mother helps with Owen in which Owen would visit her home everyday when both Kayla and Michael worked. 6. Adult Functioning: How does the adult function with respect to daily life management and general adaptation? What mental health functioning and/or substance use is apparent on a daily basis? Both parents were working-Kayla is employed with Wal-greens and Michael was employed at Food Lion however he quit and now is incarcerated with Criminal History-Civil Disturbance-February 13, 2009-R/S responded to above listed incident location in reference to a civil disturbance. Upon arrival R/S spoke with Josiah who stated that while hanging out in his room, Bagley sat on him at which time he pushed out and then Bagley knocked him off the bed. Bagley was then pushed out of the house by Josiah at which time he starting making comments about wanting to beat up. Caleb then stated that Bagley made comments that if he was not beat up that he was going home and get a gun and shoot himself. R/S then spoke with Bagley who stated that he made the comments, but that the was wanting Josiah and Caleb to let him back in the house. R/S also spoke with Bagley's parents and advised them of the incident. Nothing further at time of report. There are some concerns for Charlotte Williams-she have several last names-Charlotte Lythgoe,

IIRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM
Case Dictation

Case ID - 0001113743

Actions:

Face to Face with child/client

Staffing

Recipients:

0001545390 - Lythgoe, Kayla - [redacted]

0001556202 - Williams, larry - [redacted]

Action Date: 2/2/2010 **Action Time:** 1:30 PM **Time Spent:** 2.25

Input Date: 2/17/2010 **Input Time:** 9:16 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329

Program Service Type: Child Protective Services Assessment

Authorization:

Support Service ID:

Dictation:

PM 9:16:21 2/17/2010

Face to Face with Child/Client-2/2/2010

MDT Meeting at Levine's Children's Hospital 1:30pm

Present at the MDT Meeting were:

DSS agency David Simpson, Yvonne Stewart, Phyllis Ward, Krista Hinnant, and Dirvondra Hill.

Law Enforcement-Detective Division(York County) Detective Amanda Carter and WJ Miller

Levine's Children's Hospital: Social Worker Linda Brown, Dr. Colleen Wunderlick, Nurse Saer, Occupational therapist, and physical therapist.

The agency was informed that Owen was not able to take in enough calories by mouth and can not swallow and can not do it. The family is under the impression that the baby is doing well however the baby is not and the baby will need a G-tube placement to help him to be able to take in enough calories. This is not uncommon for babies that sustain a brain injury. Owen's sucking has regressed. If the family agrees to the g-tube placement the discharge would be pushed back to make sure there are no problems and to monitor. The recovery curve would be three months in which there will not be a lot of change after that. Owen will need lots of services for his condition. The agency was informed about the interaction between Owen and Kyla-the hospital informed the agency the interaction/bonding is minimum and Kayla is really not involved-she usually is seen sleeping a lot of the time. The Grandmother Charlotte is the one that is involved. Kayla does not really ask questions she plays with the toys during the therapy.

The family was brought into the meeting later-We were informed that Charlotte had to go home because she was not feeling well. Present from the family was Larry and Kayla. The doctor informed both Kayla

and Larry about the recommendations for Owen-Larry had some questions for the doctors and stated whatever was best for Owen is what they wanted.

Medical staff spoke about Owen being very disorganized and cant get the milk out of the bottle. The nurses have been working with Owen to measure how much calories he is taking in. There was some questions about what the family plan was before he went to hospice-they spoke about families never requested to withdraw nutrition in which they did withdrawn all care including nutrition from Owen. Owen does not have state regulation in which he just cries and screams all the time. Owen has extensive brain damage-he sees bright lights however unknown at this time if he can see. The medical staff informed the agency if we were going to bring the child into placement the foster parent would need 5 days. At this time Owen's medication has changed-he is taking seizure medication and another medication to help him. The occupational therapist stated a hearing test was performed and an eye to voice-however the child is not making much process. Owen will have a disability and require long term care. He has a problem with the reflex of tone and it does not connect-The family needs to understand these things. They have to be wiling to take what they can get and work with the child.

Actions:

Face to Face with child/client

Recipients:

0001545390 - Lythgoe, Kayla - [redacted]

Action Date:	2/2/2010	**Action Time:**		**Time Spent:**	0.25
Input Date:	2/16/2010	**Input Time:**	11:24 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 11:24:36 2/16/2010

Protective Capacity Assessment Summary:
Kayla Lythgoe is the mother to Owen. Kayla could not determine what happened to Owen in December-Owen has had several bruises on him and Kayla never paid attention to the marks. Kayla depends on her mother to make decisions for the child. Kayla appears immature-she does not bond with Owen and usually sleeps the entire time. Kayla stated that case manager needed to speak with her mother about Owen's condition.

Actions:

Face to Face with child/client

Recipients:

0001545391 - Williams, Charlotte - [redacted]
0001545398 - Carduff, Owen - [redacted]

Action Date:	2/2/2010	**Action Time:**		**Time Spent:**	0.25
Input Date:	2/16/2010	**Input Time:**	11:31 AM	**Worker:**	Hill, Dirvondra

EXHIBIT

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about a sitter for the family and informed the family about safety plan due to the incident that occurred. Case manager was informed they don't have sitter's on the 4th floor for rehab. Case manager informed them that Charlotte has been the only person caring for the child because her husband works and they have other children, Kayla is back and forth and she usually does not bond with the child. Carol stated she noticed that the Grandmother is the only person that is there always with the child. She stated she would see what she can do about the sitter. She stated however there is usually 2 people in the room that would be the sitter and the other person-she stated this is not a 24/7 thing-she stated the sitter is usually 12 hours and they pick what they want-either the 7am-7pm or the 7pm-7am. She stated they are gonna have to understand that. She stated she feels as though the child needs to be placed in foster care and the foster parent needed to be the one at the hospital instead of the family. Case manager arrived back in the room and followed up with the family-Charlotte stated-you see what Im talking about with that rocking chair. Case manager informed Charlotte that she did test the rocking chair and the only way the rocking chair could have been flipped over if she was rocking really hard in it. Charlotte stated she was not rocking hard in the rocking chair and she was rocking at a normal pace with the child. Case manger informed them again of the safety plan and information about the sitter. Charlotte begins to yell and talk in a rage at case manager. Case manager informed Charlotte they usually don't provide a sitter for this floor-Charlotte rolled her eyes at case manager. Case manager observed the physical therapist working with Owen-Owen cried and appeared not to be engaged in the activity.

Actions:

Telephone Contact

Recipients:

0001545391 - Williams, Charlotte - 03/01/1969 (E)
0001545398 - C[redacted], Owen - 09/09/2009 (E)

Action Date:	1/27/2010	**Action Time:**	10:10 AM	**Time Spent:**	0.25
Input Date:	1/27/2010	**Input Time:**	8:47 PM	**Worker:**	Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 8:47:02 1/27/2010

Supervisor contacted Lt. Miller in regards to the incident that occurred with Charlotte falling out of rocking chair with Owen and Owen hitting his head, Lt. Miller stated that Detective Carter would go to hospital to follow up. Supervisor informed Lt. that CM Hill was on her way to the hospital as well.

Actions:

Collateral Contact
Telephone Contact

Recipients:

0001545390 - Lythgoe, Kayla - 06/12/1990 (E)
0001545398 - C[redacted], Owen - 09/09/2009 (E)

Action Date:	1/27/2010	**Action Time:**	9:30 AM	**Time Spent:**	0.50
Input Date:	1/28/2010	**Input Time:**	5:12 PM	**Worker:**	Hill, Dirvondra

EXHIBIT

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reporter that Owen was doing well at Levine's Children's Hospital and the baby is no longer at Hospice-she informed the reporter they gave the baby some sugar water and the baby begin to suck the bottle and move. Detective Carter eventually came from the back and asked Case manager and Kayla to come to the back to the conference room. While in the conference room Detective Carter informed Kayla that she and case manager Hill wanted to follow up with her. Detective Carter and Case manager spoke with Kayla about the recent incident with Charlotte rocking Owen and flipping over in the rocking chair. Kayla said she was asleep on the couch when it happened. She said her mother was feeding Owen and the chair fell over and she got up from the noise of the chair. She said her mother did not go get the nurse because she was still in the rocking chair and Owen had bumped his head. Kayla informed both that her mother told her to get a nurse. When she came into the room her mother was already standing up and they did a CT scan on Owen-in which everything was fine with him. Incident that occurred with the shaking-Kayla said Sunday morning the family went to Church and Owen was fine and he did not have any bruises and nothing was wrong with him. She stated she went to her mother's home around 1-1:30pm she could not remember the exact time. She stated because she had to be at work at 2:30pm. She stated she left Owen with his father and around 10:30pm-he was not at home. She stated Michael usually take the baby for a drive however they did not come back for two hours. She stated she called and he told her that he was at McDonalds and Owen was sleep in his car seat. Kayla stated she glanced in at the baby that night however did not really check on the baby. She stated that morning the baby was crying and Michael told her that he will get the baby and she went to the restroom. She stated it was around 4am that morning. On Monday morning around 10 something-the baby was making noises and twitching-Michael was freaking out and she saw bruise on his chest-she thought that the baby may have scratched himself-they took the baby to Piedmont Medical Center because they were afraid it would take a long time for the ambulance to get to the home. Kayla talked about the baby having seizures and them transporting the baby to Levine's Children's Hospital. Case manager inquired about the scratches on his chest-she stated sometimes the baby pinches himself at night time. She stated there were no other marks/bruises on the child-she stated Owen scratched himself. December incident-Kayla stated she does not know what happened to the baby in December. Kayla stated she came home one day and Michael ran out the home holding Owen-Michael told her Owen was asleep for a long time and he woke Owen up to feed him however the baby would not eat and the baby woke up screaming and went limb. She stated they took the baby to the hospital. Case manager inquired about caregiver for the child-she stated that her mother Charlotte watched the baby all the time usually 5-6 times a week. She stated they were responsible when they watched the baby-she stated somebody always watched the baby. Case manager inquired again about any marks-including the mark that her mother observed on the baby's head in November-Kayla stated Michael said he hit himself with some keys (toy) it was on a Saturday and both she and her mother was upset about the incident. She was upset at her mother for asking her questions about the baby having scratches and marks when she did not know where they were coming from. Case manager inquired about any other marks and bruises-Kayla said no. Michael leaving the home-Kayla stated she and Michael had an argument and he left the home for about a week or four days she could not remember-she stated she kicked him our around New Years Eve and he came back on the 4th or 5th of January. She stated the argument was about him not being responsible and caring for the baby and not having a job in which he quit his job. Michael's interaction/concerns: Kayla stated Michael had not done anything to make her think that he had done anything wrong to the baby and he was never violent. She stated her mother never liked Michael because of the way he looked and he was a lazy kid and felt she could do better. She stated her mother Charlotte always disagreed with Michael. Case manager inquired about Investigation-Kayla stated she thought the investigation was closed. Case manager inquired about who told her that-she stated nobody-Case manager asked her about the conversation at the home and asked her about the booklet and brochure-she stated she remember it however she forgot all about it and did not think no more about it. She stated she felt if they were parenting classes she feel as though Michael would not have done what he done. Case manager asked her who told her about parenting classes-she stated the hospital told her then she later said DSS told her about the parenting classes. She stated she though it was over and it was closed and opened up again after the incident happened again. She stated her mother has been talking to the doctors and nurses and she don't know what is going on with Owen. She stated Case manager would need to talk to her mother about it. She stated she does not remember anything. Discipline-Kayla stated when the baby cries they usually try feeding, swing, holding and rocking the baby. She stated when she becomes frustrated she calls her mother to get the baby. Supervision/Caregivers: Case manager inquired about caregivers for the baby-Kayla mentioned her mother, Michael, and herself were the main people that watched the child. Case manager inquired about the paternal grandparents-Kayla stated they were never alone with the baby and the last time they seen the baby was for Christmas. She stated Brain would never be with the baby-she stated he was always with one of them.

Actions:

Staffing

EXHIBIT

"19"

INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 20100001027 LEAD NUMBER: _____

PERSON INTERVIEWED: Kayla A. Lythgoe

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER: _____

ADDRESS: (HOME) [redacted]

Rock Hill, South Carolina 29732 TELEPHONE: [redacted]

(WORK) Walgreens/ Rock Hill, SC

_____ TELEPHONE: _____

DATE OF INTERVIEW: January 11, 2010 TIME: _____

LOCATION OF INTERVIEW: Carolina Medical Center Main/ Charlotte North Carolina (Levine)

PURPOSE/TOPIC OF INTERVIEW: Injuries to Owen C[redacted]

DETAILS OF INTERVIEW:

Kayla said that she works for Walgreens in Rock Hill, South Carolina. Kayla said that she awaken Monday morning and that she heard her baby making noise, (A whimper). Kayla said that she went into his room and that he was twitching. Kayla said that Owen was blinking and that his eyes were open and positioned to the side of his eyes.

Kayla said that she yelled for Michael, (Owens father). Kayla said that she took the blanket off of him and discovered that Owen had a bruise on his chest. Kayla said that she pinched Owen on his right arm as she was told by doctor to do the first time that Owen was unresponsive.Kayla said that Owen had on only a diaper because he sweats when he sleeps.

Kayla began to retract what happened before she discovered Owen twitching. Kayla said that on Sunday morning that they, she, Michael and Owen went to church. Kayla said that this was the last time that she saw Owen undressed before his injuries. Kayla said that while at church that Owen vomited on himself and that she changed his clothes. Kayla said this was about 11:30 or 12:00. Kayla said that her mother invited them over to eat Chili and that Michael did not want to go so she went to her mothers and that she left from her mother's home to go to work. Kayla said that she went to work around 2:30pm. Kayla said that she did text Michael throughout the day asking him how was Owen doing. Kayla said that Michael told her that Owen was cranky.

Kayla said that on Sunday night that she got home from work a little after 10:30pm. Kayla said that when she arrived home that Michael nor Owen was there. Kayla said that Michael returned to the residence about 2 hours later.

Kayla said that she did not actually see Owen when Michael and he arrived on Sunday Night. Kayla said that Michael was carrying Owen in the car seat and that he was asleep and wrapped up in a blanket. Kayla said that Owen does wake up during the night and that normally she is the one that gets up with him. Kayla said that however, on Monday Morning around 4:00 am that she awaken, got up and went to the bathroom and that she intended to go in and check Owen. Kayla said that Michael got up with Owen which was very unusual because this was the first time he ever got up with him at night. Kayla said that she saw Michael and what she thought was him trying to give Owen a bottle. Kayla said that she was going to go further into the room when Michael told her, "I got it". Kayla said that she got back into bed.

Kayla said that another thing was strange. Kayla said that once I appeared to interview the family that Michael said to her, " I forgot to tell you that Owen did hit his head on the Rocking Chair". This was his explanation for the bruise on his head.

Kayla said that on Sunday night that she got home from work a little after 10:30pm. . Kayla said that the week before that Owen did sleep alot and that she took him to Riverview. Kayla said that they told her that nothing was wrong with him. Kayla said to her he was acting strange and that she took him to his Pediatric at Sunshine.

Kayla said that his doctor said that Owen had a throat infection but they did not give him any medicine. Kayla said the other time that she was at work and that when she pulled in the driveway that Michael ran outside with Owen saying that he was cranky. She said Michael said he woke him up for a bottle and Owen did not eat. Kayla said Owen screamed and passed out. Kayla said he just went limp. Kayla said, "sometimes, Michael picks up Owen to quick or handle him to rough, I have to tell him to be easy". Kayla said , "I don't think Michael would intentionally do anything but they say it is Shaken Baby Syndrome". Kayla said that she had just let Michael move back in. Kayla said that she put him out because he lost his job because he wouldn't go to work and that she told him he had to work.

OFFICER / AGENT: Amanda P. Carter

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EXHIBIT 19

INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 201000001027 LEAD NUMBER: _____

PERSON INTERVIEWED: Kayla A. Lythgoe

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER: _____

ADDRESS: (HOME) [redacted]

Rock Hill, South Carolina 29732 TELEPHONE: [redacted]

(WORK) Walgreens/ Rock Hill, SC

TELEPHONE: _____

DATE OF INTERVIEW: January 28, 2010 TIME: _____

LOCATION OF INTERVIEW: Moss Justice Center

PURPOSE/TOPIC OF INTERVIEW: Injuries to Owen C[redacted]

DETAILS OF INTERVIEW:

*This interview was scheduled before Polygraph for verification purposes

On this date Kayla was interviewed again and she was consistent with her last statement. Kayla said Sunday Morning we went to church and Owen was fine. He spit up and she changed his outfit. They, (she, Michael,Owen) went back home. She went to Moms for dinner left mother residence and went to work.

Kayla said she got home about 10:30 pm and that Michael and Owen was not there. Kayla said that Michael came in about 2 hours later and Owen was asleep. Kayla said she got up to go to restroom at approximately 4:00 am and that Michael was changing Owen and she looked in the room and he told her that he had it.

Kayla said that at about 10:00 am that she heard Owen making a squeaky noise. Kayla said that she called Michael and he came into the room. Kayla said that she uncovered Owen and asked Michael how Owen got the bruises. Kayla said that Michael told her that he didn't know. Kayla said that she thought that maybe Owen had scratched himself. Kayla said that they took Owen to Piedmont Medical Center.

Kayla said that Michael told her when he came in with Owen the night before that they just rode around and that he went to MacDonald's to get him something to eat.

Kayla said that she kicked Michael out of the house because they argued about him not having a job. Kayla said that she kicked him out on New Years Eve. Kayla said it was at least a week before this incident with Owen.

Kayla said that on Saturday that her Mom saw a bruise on Owen's head and asked her where did Owen get the bruise and that she offered to keep Owen because of the bump. Kayla said that Michael told her that this bump was from Owen playing with his plastic keys. Kayla said but at the hospital he told her that he bumped his head on the Rocking Chair.

Kayla said that on December 4, 2009 that she came home from work and that Michael ran out with Owen and that Owen was completely limp. Kayla said that Michael told her that Owen was asleep and that when he awaken that he tried to feed him and that Owen would not take his bottle. Kayla said that Michael told her that Owen yelled out and went limp. Kayla said that on December 5, 2009, that Owen was transferred to Carolina Medical. Kayla said that Michael never showed any anger toward Owen. Kayla said, "I did thought that it was odd that night that Michael got up with Owen because Michael never got up with Owen or helped with him unless I asked".
Kayla said that she with the help of her Mom decided to discontinue the Life Support for Owen. Kayla said that they decided that it was not good for him to live like that.

OFFICER / AGENT: Amanda P. Carter

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SHER 000020

Kayla said that on the December 4, 2009, episode that Owen did not have any marks or bruises. Kayla said that he did have a bleeder in his head and that she was confused because she did not know how babies just bleed. Kayla said that one of the Nurses told her that infants could do that in the Womb.

Kayla said that the Nurse told her that there is not a cause for everything. Kayla said that the hospital did a full body scan.

Kayla said now, it seems that everything happened bad to Owen that he was in Michael's care. Kayla said that "I think that's kinda weird".

Kayla said that when her Mom asked about the bruise on Owens's head on Saturday that she told her Mom, "don't start". Kayla said that the reason she said that was because her mother never liked Michael and that she disliked how he looked. Kayla said that her mother said that he was lazy and a kid and that she could do better.

Kayla said that "I think if we had gotten the parenting classes that this may not have happened. That we would be more educated on caring for a baby.

*Note

1/28/10

*Charlotte and Owen flipped Rocking Chair at Levine

Kayla said that she was asleep and that her mother was feeding Owen and that she woke up to a crash. Kayla said that her mother told her to get the Nurse and that she did. Kayla said that when she came back into the room that her mother and Owen was up off the floor.

Kayla said the chair was on the floor and that Owen cried.

INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 20100000 LEAD NUMBER: _____

PERSON INTERVIEWED: Jennifer Carduff

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER: _____

ADDRESS: (HOME) [redacted] Concord, North Carolina

TELEPHONE: [redacted]

(WORK) _____

TELEPHONE: _____

DATE OF INTERVIEW: 1-11-10 TIME: _____

LOCATION OF INTERVIEW: Carolina Medical Center Main/ Charlotte North Carolina

PURPOSE/TOPIC OF INTERVIEW: Child Abuse of Owen C[redacted]

DETAILS OF INTERVIEW:

Mrs. Carduff is the Paternal Grandmother of 4 month old, Owen C[redacted]

Mrs. Carduff said that she met her son at Carolinas Medical Center after receiving a phone call that they were bring Owen to the hospital from Rock Hill there.

Mrs. Carduff said she does not know anything except that the last time that Owen was here at Carolina's that they had a team of at least 5 doctors and that they never gave an explanation as to how Owen's injury occurred.

Mrs. Carduff said they told them then that the injury was not severe enough to do Surgery to eliminate the pressure.
Mrs. Carduff said that there was pressure on the brain then like now and that they never got the results.

OFFICER / AGENT: Amanda P. Carter

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SHER 000022

INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 2010 LEAD NUMBER: _____

PERSON INTERVIEWED: Charlotte Williams

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER: _____

ADDRESS: (HOME) [redacted]

Rock Hill, South Carolina 29730 TELEPHONE: _____

(WORK) _____

_____ TELEPHONE: _____

DATE OF INTERVIEW: 1-11-10 TIME: _____

LOCATION OF INTERVIEW: Carolina Medical Center Main/ Charlotte North Carolina

PURPOSE/TOPIC OF INTERVIEW: Child Abuse of Owen C[redacted]

DETAILS OF INTERVIEW:

Mrs. Williams is the Maternal Grandmother of 4 month old victim, Owen C[redacted]
Mrs. Williams said , "I knew this was coming". Mrs. Williams said that she had her suspicions of Michael abusing the baby since November. Mrs. Williams said that in November that the baby had a bruise on his forehead and that Mike and his brother Brian had kept the baby all day. Mrs. Williams said that she told her husband that she wanted to keep the baby more because of what she suspected and that her husband told her that Michael has to become responsible.

Mrs. Williams said that she was holding Owen on Saturday Night and that she noticed a scratch bump and bruise on his forehead at the hair line. Mrs. Williams said she asked Michael about it and that he told her, he must have gotten the injury in the crib because he said that he leaves him in the crib by himself. Mrs. Williams said that she told him that babies scratch themselves but that this wasn't a baby scratch. Mrs. Williams said that Michael told her that he did not know what happened.

Mrs. Williams said she didn't see any other bruises on Owen. Mrs. Williams said that Mike is rough with the baby. Mrs. Williams said that he has had to be reminded that when he picks the baby up that he needs to hold the baby's head. Mrs. Williams said that when she saw the bruises, bump and scratch that she was really upset. Mrs. Williams said that she was upset with her daughter Kayla. Mrs. Williams said that the reason that she was upset with Kayla was because she didn't like Kayla's respond of "oh, don't start that again". Mrs. Williams said that she believes that Kayla is protecting Michael. Mrs. Williams said that the last time that she saw Owen was Sunday Morning that they Owen, Kayla and Michael was at church.

Mrs. Williams said that Owen looked fine. Mrs. Williams said after church services that she had cooked Chili and that Kayla came over for Dinner. Mrs. Williams said that she asked Kayla where was Michael and Owen and that Kayla told her that Ugly. Mrs. Williams said that Kayla came to her home about 1:30 pm.

Mrs. Williams said Kayla left her residence and went to work. Mrs. Williams said, "I am concern and trying to figure out, why did DSS close the 1st case so soon". Mrs. Williams said she also want to know what happened to the Parenting classes that DSS was suppose to be setting up for Michael and Kayla.

Mrs. Williams said that Michael and his brother plays Video games 24/7. Mrs. Williams said that Kayla had kicked Michael out of the house because when the last incident happened while the baby was in the hospital that Michael would not go to work and that he lost his job. Mrs. Williams said that apparently she let him back in.
Mrs. Williams said that she remembers Michael was talking baby talk to the baby over her house and that Kayla said that Michael never talks to the baby at home. Mrs. Williams said that as far as Michael rocking Owen in the rocking chair that she has never seen Michael rock Owen and she does not believe they ever use that rocker. Mrs. Williams said that he usually just stick Owen in his swing.

OFFICER / AGENT: Amanda P. Carter

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EXHIBIT

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INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 2010 LEAD NUMBER: _____

PERSON INTERVIEWED: Charlotte Williams

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER: _____

ADDRESS: (HOME) [redacted]

Rock Hill, South Carolina 29730 TELEPHONE: _____

(WORK) _____

_____ TELEPHONE: _____

DATE OF INTERVIEW: 1-11-10 TIME: _____

LOCATION OF INTERVIEW: Carolina Medical Center Main/ Charlotte North Carolina

PURPOSE/TOPIC OF INTERVIEW: Child Abuse of Owen C[redacted]

DETAILS OF INTERVIEW:

Mrs. Williams is the Maternal Grandmother of 4 month old victim, Owen C[redacted]
Mrs. Williams said, "I knew this was coming". Mrs. Williams said that she had her suspicions of Michael abusing the baby since November. Mrs. Williams said that in November that the baby had a bruise on his forehead and that Mike and his brother Brian had kept the baby all day. Mrs. Williams said that she told her husband that she wanted to keep the baby more because of what she suspected and that her husband told her that Michael has to become responsible.

Mrs. Williams said that she was holding Owen on Saturday Night and that she noticed a scratch bump and bruise on his forehead at the hair line. Mrs. Williams said she asked Michael about it and that he told her, he must have gotten the injury in the crib because he said that he leaves him in the crib by himself. Mrs. Williams said that she told him that babies scratch themselves but that this wasn't a baby scratch. Mrs. Williams said that Michael told her that he did not know what happened.

Mrs. Williams said she didn't see any other bruises on Owen. Mrs. Williams said that Mike is rough with the baby. Mrs. Williams said that he has had to be reminded that when he picks the baby up that he needs to hold the baby's head. Mrs. Williams said that when she saw the bruises, bump and scratch that she was really upset. Mrs. Williams said that she was upset with her daughter Kayla. Mrs. Williams said that the reason that she was upset with Kayla was because she didn't like Kayla's respond of "oh, don't start that again". Mrs. Williams said that she believes that Kayla is protecting Michael. Mrs. Williams said that the last time that she saw Owen was Sunday Morning that they Owen, Kayla and Michael was at church.

Mrs. Williams said that Owen looked fine. Mrs. Williams said after church services that she had cooked Chili and that Kayla came over for Dinner. Mrs. Williams said that she asked Kayla where was Michael and Owen and that Kayla told her that Ugly. Mrs. Williams said that Kayla came to her home about 1:30 pm.

Mrs. Williams said Kayla left her residence and went to work. Mrs. Williams said, "I am concern and trying to figure out, why did DSS close the 1st case so soon". Mrs. Williams said she also want to know what happened to the Parenting classes that DSS was suppose to be setting up for Michael and Kayla.

Mrs. Williams said that Michael and his brother plays Video games 24/7. Mrs. Williams said that Kayla had kicked Michael out of the house because when the last incident happened while the baby was in the hospital that Michael would not go to work and that he lost his job. Mrs. Williams said that apparently she let him back in.
Mrs. Williams said that she remembers Michael was talking baby talk to the baby over her house and that Kayla said that Michael never talks to the baby at home. Mrs. Williams said that as far as Michael rocking Owen in the rocking chair that she has never seen Michael rock Owen and she does not believe they ever use that rocker. Mrs. Williams said that he usually just stick Owen in his swing.

OFFICER / AGENT: Amanda P. Carter

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EXHIBIT

"21"

about it & Kayla got defensive & they would not let her (Charlotte-gm) hold him in Church or get him after Church

Mr Williams is a pastor

Ophthalmologist opened baby at 7:00 pm & there was bleeding behind retina (retinal hemorrhage

Mom left hospital to accompany Michael to get his polygraph & did not get back to the hospital - more worried about Michael than the baby

Gm noticed a scratch on baby forehead in Nov & then noticed a bruise on forehead on S; 1/9

- we made LE referral after Dec incident

- MGM took picture of Nov bruise & asked Michael & uncle Brian Cardiff about it & they said no clue how it occurred - Kayla had not even seen it

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Training Issues -
developmental steps
Subdural hematomas - DS

EXHIBIT 21

EXHIBIT

"22"

PM 3:01:31 1/12/2010

Supervisor contacted Lynn Myers, Child Maltreatment Coordinator at Levine Children's Hospital (704-355-4088 pager # 7814). Lynn expressed concerns that Charlotte Williams (maternal grandmother) may have known about Owen and him being shaken. Lynn stated that the Grandmother has told hospital staff that she has seen bruises on the child. Supervisor asked Lynn about the Grandmother having contact with the child while the child is at the hospital. Lynn stated that everyone who visits Owen is having supervised contact. Lynn stated that nursing staff is supervising the contact and that they have had to ask visitors to leave when nurses are unavailable to supervise. Lynn stated that Owen's conditions is deteriorating. She stated that it is possible that he will not make it. Lynn stated that Owen was seizing this morning and that the child is going to have surgery to put a stint in to drain the blood/fluid off of his brain. Lynn stated that the mother is currently at the hospital. Supervisor provided Lynn with contact information to update Supervisor with any new information.

Actions:

Collateral Contact

Telephone Contact

Recipients:

0001545398 - Carduff, Owen - 09/09/2009 (E)

Action Date:	1/12/2010	**Action Time:**		**Time Spent:**	0.50
Input Date:	1/12/2010	**Input Time:**	10:03 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 10:03:07 1/12/2010

Collateral Contact Called Levine's Hospital to speak with Laura McDowell regarding any updates-case manager was informed that Laura was not at the desk and she would give Laura the message to call case manager back when she get off the phone-case manager inquired about the condition of the child-case manager was informed they were doing a plug on the child-case manager inquired what a plug was-she stated a plug is when they take fluid out to release the pressure in the brain.

Actions:

Collateral Contact

Recipients:

0001545398 - C[redacted], Owen - 09/09/2009 (E)

Action Date:	1/12/2010	**Action Time:**		**Time Spent:**	0.50
Input Date:	1/12/2010	**Input Time:**	3:04 PM	**Worker:**	Hinhant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

EXHIBIT
22
429

EXHIBIT

"23"

Cm made telephone contact with Charlotte Williams to inform her that the home study was found to be unfavorable and Owen will not be placed with her. Charlotte questioned why and cm explained to her about their criminal history and the department can not place a child with someone who has criminal history. Charlotte asked if Owen could be placed with Michael's parents and cm explained that is a possibility but we will also have to do a homestudy on them. Charlotte then asked where Owen was going to go since he is being discharged today and cm explained she did not know the answer to that as of right now. Charlotte was upset about the homestudy and stated that she did not understand since her charges were misdemeanors. Charlotte wanted to know if she could fight the finding of the home study and cm stated that a court would have to over rule. Cm asked Charlotte where Kayla was because cm needed to speak with her and Charlotte stated that she was at the hospital and could be reached on her cell phone.

Actions:

Face to Face with child/client

Recipients:

0001545391 - Williams, Charlotte - 03/01/1969 (E)
0001556202 - Williams, larry - 04/02/1959 (E)

Action Date:	2/16/2010	**Action Time:**	2:15 PM	**Time Spent:**	1.00
Input Date:	2/22/2010	**Input Time:**	11:43 AM	**Worker:**	Hemphill, Diva

Service ID: 0001395295
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 11:43:45 2/22/2010

CW Hemphill arrived at [redacted] in Rock Hill the home of Larry and Charlotte Williams. CW informed both Mr. and Mrs. Williams of the current allegations. Charlotte spoke about the incident of her falling out of the rocking chair while holding Owen at the hospital. She reported that she was holding him up on her shoulder and he was sliding down towards her chest area. She reported she was burping Owen when the incident occurred. She reported that she was trying to slide him back up to her shoulder when she went back the chair flipped and both her and Owen fail out of the chair. She reported he hit is head a little and cried a little. She reported she was taking with the nurse right before the incident occurred and as soon the nurse walked out of the room that was when the rocking chair flipped. She stated that it was reported that she was going at a very high rate of speed, but she denied that she was going fast. She reported that the nurse even said she was not going fast while she was present in the room. She stated that she did not mean to flip the chair over and it happen. Mrs. William reported Kayla was in the room on the couch asleep when the incident occurred. She stated that Kayla got up as soon as the incident happen and asked if she was alright. CW addressed the concerns of Mr. Williams feeding Owens after the family had been informed they were not allowed to feed him only the doctors. Mr. Williams reported he never feed Owen at the hospital or at hospice. He stated when he realize Owen could eat while at hospice he did go home and get a bottle for him to drink out of, but hospice did not use the bottle nor did he. He stated hospice feed Owen sugar water, but deny him ever feeding Owen when they had been informed not to do so by nurses. Both admitted to a verbally agreement regarding Owen receiving a feed tube. Charlotte reported the doctors had spoken with them about putting a feeding tube in Owen. She reported later on that same afternoon after speaking with them about the feeding tube the doctor came in for the consent to be sign and Kayla was at work. She reported she explained to the doctor that Kayla was at work and could sign the feeding tube tomorrow morning. She stated they informed her the consent had to be signed that night. She reported she contacted Kayla over the phone and Kayla gave and verbally concert over the phone. She reported through the night they talked among themselves and others and decided they did not want Owen to have the feeding tube. She reported that her brother is a medical doctor and he had advised them not to do so. She reported the next morning they informed the hospital that they decided not to go with the feeding tube and wanted to know if they had other choices. She reported that Kayla never did rip the consent up because she never did

EXHIBIT

"24"

Transcript of Recordings
Labeled "Lola DSS (Part 1)"
and "Lola DSS (Part 2)"
Dated 12/17/2009

- - - - - - - - - - - - -

Transcribed by: Audrey S. Beebe,
Southern Reporting, Inc.

LOLA: York County DSS. This is Lola. How may I help you?
LIEUTENANT MILLER: Where have you been hiding?
LOLA: 18 West Liberty Street, down the hall.
LIEUTENANT MILLER: You have?
LOLA: Yeah. How are you doing, W.J.?
LIEUTENANT MILLER: I'm doing good right this second.
LOLA: That's good.
LIEUTENANT MILLER: But is Devondra Hill still Christa Hemmett's?
LOLA: Yes, she is. And they are both not in the office.
LIEUTENANT MILLER: Oh, no shit.
LOLA: Yeah. They ran away.
LIEUTENANT MILLER: I -- sometimes I -- you know, I try not to get upset, and I --
LOLA: I know.
LIEUTENANT MILLER: -- I probably shouldn't.
LOLA: Uh-huh. You're safe.
LIEUTENANT MILLER: But why would I get a DSS report of a one-year-old child who has two subdural hematomas and a flax [sic] subdural hematoma today when it was -- the child was taken to Piedmont on December the 2nd and then transferred to Charlotte? Why would I get that today?

LOLA: I don't know.
LIEUTENANT MILLER: And I -- and I'm not asking you to answer any questions. You're my sounding board.
LOLA: Yes, I know. I know. And --
LIEUTENANT MILLER: And -- but that just infuriates the living hell out of me, because in the statement that says that the child has a -- none of the -- the parents don't know anything about any falls.
LOLA: Yeah. That's one from on-call that Shondra Tyler went out on the 6th. Me and her sent that out, and we staffed it with them on Monday.
LIEUTENANT MILLER: And I do not --
LOLA: So you haven't --
LIEUTENANT MILLER: I don't have -- there's not a report on it where law enforcement was called --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- or nothing.
LOLA: Uh-huh. Yeah. They had that for the 7th to follow up on.
LIEUTENANT MILLER: Why --
LOLA: Yeah. So you got it today?
LIEUTENANT MILLER: Yeah. I just got it when I walked in the door.
LOLA: I don't know.
LIEUTENANT MILLER: It was sent on the 16th --

LOLA: -- which was last --
LIEUTENANT MILLER: -- which would've been last night. Well, it came in at six -- almost seven o'clock last night.
LOLA: Yeah.
LIEUTENANT MILLER: You know, I just -- I try my best.
LOLA: Uh-huh.
LIEUTENANT MILLER: Now, if anything's going to stroke me out, this -- this will.
LOLA: Yeah. The (inaudible) --
LIEUTENANT MILLER: Things like this will, but the other stuff that I know about, we can deal with. But I just -- I don't understand -- they'll send me something over here about a child having sex with somebody.
LOLA: Uh-huh. Oh, that's right away, right? But not the other one.
LIEUTENANT MILLER: Yeah. But they won't send me where a one-year-old child's got damn bruising on its brain.
LOLA: Uh-huh. Yeah. That -- and that was staffed on the 7th because I passed that on to them, and it was discussed, and it's law enforcement referral. So, yeah, I can't explain what happened.
LIEUTENANT MILLER: I guess my main thing is: Did --

EXHIBIT 24 gibbler

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was DSS called out?
LOLA: Yeah, it was. Because I sent Shondra Tyler out. That was --
LIEUTENANT MILLER: That day or that night -- whatever that -- whenever it was?
LOLA: Yeah. That night I sent her out to the hospital, and then we brought the report in the next day and sent -- and staffed it and passed the report on to the assigned caseworker. And we staffed that case, and they had all the information, and they were going to make their law enforcement referral.
LIEUTENANT MILLER: Well, let me ask you this question: Why were we not called that night?
LOLA: Because the child was in the hospital, and the parents appeared to be appropriate. And they didn't think that it was -- oh, because the information was -- they thought that we were coming up there to release the babysitter. After the worker went up there and followed up with the report, no doctor had said that the child had a non-accidental injury. Staff thought that DSS was there to release the sitter so they could -- so the sitter could go home, and there was no concerns for the child, that it was accidental.
So I didn't send law enforcement up there with

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her on that report. Child was in a safe place. She was -- went up there. She wasn't saying that it was not -- non-accidental, the social worker that had called. There's an injury -- she -- they had that report on -- that baby was there on Saturday.
That baby has been to four different doctors. That family picked that -- that child was -- November 30th went to the doctor, December 2nd went to Riverview. The 4th -- there was one appointment at Sunshine, and then Friday, the 4th, the baby went to PMC. And then PMC sent the baby to Charlotte on Saturday, and then Sunday the hospital called us.
So that baby's had four other -- not hospital, but doctor visits, and the doctor has continuously sent the child home. But the family has responded to the child appearing limp because the -- Friday the incident was the worst. So, no, I didn't send law enforcement out. Child was in a safe place. We have to get the information. We have to find out what's going on.
LIEUTENANT MILLER: Uh-huh.
LOLA: And we brought the case in the next day and staffed it.

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LIEUTENANT MILLER: Okay. What -- well, I guess -- I guess my question is -- and I'm just -- all I'm doing is throwing stuff at you because I'm trying to figure out what's going on.
LOLA: Uh-huh.
LIEUTENANT MILLER: Is they're saying -- the parents are saying that -- at least in the DSS report -- that this child hasn't fallen, hasn't hit his head on anything, or none of that stuff.
LOLA: Yes. Yes.
LIEUTENANT MILLER: And --
LOLA: And that's what they told the on-call worker too, that they're not aware. And then it was like they said the same thing. And I'm -- the medical records, I don't know what's happened with those, what -- what the end results were with those. So nobody has an answer as to why or how that child was injured. There was a question of an uncle, though.
LIEUTENANT MILLER: Yeah. The --
LOLA: Dad and --
LIEUTENANT MILLER: The babysitter or the -- or the mother went and picked them up from the daddy and the uncle, or what was -- there was something in there about that.

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LOLA: No. What I remember is: The uncle was with the dad.
LIEUTENANT MILLER: Right.
LOLA: They were the two that were left alone with the child on one occasion, and that was per the grandma who told the social worker or the nurse at the hospital. So, yeah.
LIEUTENANT MILLER: Would that --
LOLA: We have 24 hours to make our referral too, and I mean, that's no excuse or whatever, but it's like, "You know what? We'll go out there and we'll initiate our contact, make sure that child -- they don't leave against medical advice." They were cooperative. And then -- then next day, assign it to the caseworker. It's like, "You're the one that needs to get out there and find out what's going on, follow up with that," because we don't need ten caseworkers at court.
LIEUTENANT MILLER: Uh-huh.
LOLA: I don't know. Devondra's back in the office. I heard her voice. You want to ask her why they waited? I mean, I -- I don't know, W.J.
LIEUTENANT MILLER: Okay. Yeah. I definitely want to talk to her. But I just -- you know -- you know I'm going to call you first.

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LOLA: Yeah.
LIEUTENANT MILLER: Because I know there's always more to a story than what I'm actually reading here. But I just --
LOLA: Yeah.
LIEUTENANT MILLER: I -- I can't understand how I -- how I get this, you know, seven or eight days later.
LOLA: Yeah. And --
LIEUTENANT MILLER: And -- and -- but I get this other crap immediately.
LOLA: Yeah. The hospital staff, per Shondra after the -- after she had gone out there and when she was ready to leave, a nurse and another staff person came up to her and said, "So are you releasing the sitter now so they can go home?" And they were surprised that we were even there otherwise, pointing the finger at the parents. Shondra Tyler. And then that was upsetting to me because, like, why -- you thought we would just go up there and release your sitter. We thought you were calling because you thought there was physical abuse, but no doctor had stated that. And Christa's also followed up and called the doctor the next day, or somebody on staff there -- Bridgette, I think.
LIEUTENANT MILLER: Okay.

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LOLA: So they would have a bit more information, too, than what would be on that report, but -- you know, I -- it still should've -- we had 24 hours; it still should've gone out on the Monday by the latest.
LIEUTENANT MILLER: Yeah. I just don't -- I don't know.
LOLA: Yeah. Because you have Shondra Tyler who interviewed the people, and then whoever -- Devondra Hill, if she interviewed anybody, would have whatever she has also. So -- but I made the call not to call law enforcement that night.
LIEUTENANT MILLER: Okay.
LOLA: I had 24 hours. And then it was being passed on to the next worker. So -- but that baby's been to four different appointments prior to getting to Pineville. That did not -- this appears to be something that's been going on since 11/30, and the parents kept taking the child to a doctor or to Riverview Clinic or then to the hospital. And they just kept getting turned around, "Everything's fine. Everything's fine." Except for the 4th. Friday the 4th, that -- the hospital said, "No. Everything's not fine."
LIEUTENANT MILLER: Okay. What's -- who was the uncle? because I don't see anything on here about his name

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or anything other than "uncle."
LOLA: Oh, okay. Hang on. I'm going to move my phone, and if I lose connection --
LIEUTENANT MILLER: Well, I'll tell you what: No. There's no need in you having to deal with this. I left a -- a message for Christa -- Christa Hemmett to call me back.
LOLA: Uh-huh. And she's gone on home visits, but she should be back this afternoon.
LIEUTENANT MILLER: Right. I've left a message. She can call me on my cell phone or home phone as long as this child seems to be in decent custody right now.
LOLA: Yeah. Because it's -- or the child, I think, is at home, right? Is that what your report says?
LIEUTENANT MILLER: It doesn't say.
LOLA: It doesn't? What -- what's her name?
LIEUTENANT MILLER: Her name is -- or his name is Owen C[redacted]
LOLA: [redacted]
LIEUTENANT MILLER: [redacted]
LOLA: Okay. All right. I'm -- I -- I'll just pull it up right here, and let's see if her dictation shows who that uncle was that she had spoke to, because she was supposed to say. Let's see. It's Owen --

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Jennifer's the -- Brian Carduff is the uncle. He's the paternal uncle, Brian Carduff. "In the beginning, Owen's -- change in Owen's behavior that they first noticed was on 11/28, sleeping, screamed a lot nonstop." They took him to Riverview Clinic on 11/28. Doctor said nothing was wrong. Then --
LIEUTENANT MILLER: Do you have the address and telephone number for the uncle?
LOLA: No. But I think he lives there with them. My understanding --
LIEUTENANT MILLER: At the same house?
LOLA: Yeah. My understanding is he's living at that home.
LIEUTENANT MILLER: Okay. [redacted]?
LOLA: Yes. Yeah.
LIEUTENANT MILLER: And -- wait. Are you finding anything else in there?
LOLA: Oh, okay. So 11/28 he went to Riverview Clinic. Then on 12/2 he went to Sunshine Peds. Doctor said he had a sore throat -- had a throat infection and a minor cold. 12/4 the baby was limp; they rushed him over to Piedmont. Then he was transferred to Levine. That was 12/5 like around two o'clock in the morning, I guess. I remember there -- something said about that. And then -- so that's

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three appointments that he went to where people -- because the baby was going limp. And I don't know what the medical records are.

My -- she checked out the play packs or whatever the child sleeps in. A small, flat, brownish bruise on the left side of his head was noticed in November, which was probably the 28th. No idea where it came from. "Owen head turns and jerks around sometimes during tummy time on the floor." Oh, uncle has been in their home with either parent.

LIEUTENANT MILLER: He's what?

LOLA: Uncle might not live there. Uncle said that he never watched the children alone, but he has been in the home with either parent and watched when they did things around the house. So that's probably -- that's probably not the uncle's address. But Devondra or Christa should have that address for the uncle. She doesn't have that in her dictation here. Let's see.

Well, and then, too, Levine's stuff -- oh, no. Owen -- our -- we stopped our case so I guess they stopped the case, and the child was allowed to go home. Second T -- second CT scan was stable. That was on 12/7. Owen -- yeah. So he was discharged.

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Okay. I'm not seeing another address for the uncle, but Devondra may have that. What day is that? I mean, that day -- it was done on a Monday. No. She didn't put the address of the uncle in here.

LIEUTENANT MILLER: Okay.

LOLA: Yeah. Christa will probably follow up with you because she had called and talked to a doctor, and 12/7 the hospital could not determine where -- whether the injuries are accidental or non-accidental. Bones, eye exam, skeleton survey were negative. His head still appeared swollen, though, on the 7th. Family has no clear history of trauma. The hospital -- however, the hospital cannot rule out any trauma. So their concern was lack of supervision.

LIEUTENANT MILLER: Well, see, yeah, that's -- that's my whole thing is: How did this child's head get bruised up like this?

LOLA: Uh-huh.

LIEUTENANT MILLER: And nobody knows. You know, he wasn't crying sometime?

LOLA: He was. He was. See, and that -- all -- he was showing signs and symptoms, and that's why the family started reacting. 12/7, Laura stated, "At this point there are no obvious signs of abuse or neglect," but they were going to follow up with the family in two weeks. Yes, there was.

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LIEUTENANT MILLER: What I'm saying --

LOLA: (Inaudible.)

LIEUTENANT MILLER: But what I'm saying is --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- that sometime, if he would've had these bruises come up on his head, he would've started crying at that time.

LOLA: Yeah. See, now, they noticed the change in his behavior. He was sleeping a lot, screamed a lot nonstop. That was 11/28. Then he was taken to Riverview. Riverview doctor said nothing wrong with him. "Owen continued the abnormal behavior through the week on 12/1 and went all day and night without urinating."

So then they took -- they scheduled an appointment with the pediatrician for the 2nd, and they took the child there. That doctor said a sore throat and a minor cold, no medicine.

Then on 12/4, pulling in the driveway, Michael came outside -- Michael, the dad, came outside and said that Owen just went limp. He was still breathing. They rushed him to the hospital. "At the hospital, Owen let out a loud scream and took a huge breath." And that's what she put.

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And then -- so they've noticed these behaviors, and they were following up with the doctor on these behaviors. But nobody -- the doctors were saying everything was fine until Friday the 9th. Mr. Carduff said Owen was sleeping a lot, he wasn't eating. He'd wake -- woke him up to feed him. He'd let out a loud scream, stretch out, was turning red and went limp. So that was the 4th.

But they were noticing -- the parents were noticing the child's behavior wasn't -- did not appear right, and they would take the child to the doctor. And there's only that one time where that bruise on his head -- the little brownish -- small, flat, brownish bruise. So that would've -- that was in November. That would've been the 28th.

LIEUTENANT MILLER: Uh-huh.

LOLA: A small, flat, brownish bruise on the left side of his head; they noticed that. And they did not know where it came from. Again, back to "Owen's head jerks -- turns and jerks around during tummy time on the floor." So it may -- I mean, if it is lack of supervision, you can hit something with it,

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and -- and they weren't in the room, had something there that shouldn't have been. But again, too, he's only a small baby.
LIEUTENANT MILLER: Right. I can -- you know, I've got a grandson that's almost one year old, and I know he can bounce, you know --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- and crack his head, do whatever. But --
LOLA: Yes.
LIEUTENANT MILLER: -- my thing is -- is, unless you leave him alone --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- you know, for hours at a time, if a child falls and hits their head hard enough --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- that there's an internal brain bruise --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- which my understanding of the --
LOLA: Hematomas?
LIEUTENANT MILLER: -- falx -- well, the falx subdural hematoma --
LOLA: Uh-huh.
LIEUTENANT MILLER: You know, other than bruising, you

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know, they'll cry for a little while and then they'll quit or either go to sleep or something like that. But that one that went behind the -- I guess it's behind the skull --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- you know, that's not something they usually get by just falling.
LOLA: Right.
LIEUTENANT MILLER: And that's why -- that's -- I guess that's my main concern is that -- had it just been, you know, a couple of bruises where it could've been, you know, the playpen or the crib or something where he climbed up and slipped and fell and hit his head, that's a different story.
LOLA: Right.
LIEUTENANT MILLER: But when you got a child going limp and, you know, not acting right and doing all that kind of stuff, and then you get in there and you got a bruise behind the skull --
LOLA: Right.
LIEUTENANT MILLER: -- there's something.
LOLA: Yeah. Something happened.
LIEUTENANT MILLER: Yeah.
LOLA: Something happened. Yeah.
LIEUTENANT MILLER: So that's -- I guess that's my

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biggest thing, and then I -- I -- my whole thing was just to call up and bitch.
LOLA: Uh-huh.
LIEUTENANT MILLER: Because I figured I'd get to the end of it sooner or later, but I just don't like little children -- you know, one minute --
LOLA: Right.
LIEUTENANT MILLER: One minute -- there's no consistency, I guess, is what I'm saying.
LOLA: Yeah. There isn't, W.J. Wholeheartedly, there is not.
LIEUTENANT MILLER: And I guess that's what gets me. Because I can get something, you know --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- like these kids with the dogfighting and stuff, you know.
LOLA: Oh, yeah, that was a good one.
LIEUTENANT MILLER: You know, we get those and then we got the ones whose Mama and Daddy's smoking pot, you know, and that kind of stuff, you know, immediately --
LOLA: -- and these ones you're not?
LIEUTENANT MILLER: -- so -- huh?
LOLA: And this one you're not?
LIEUTENANT MILLER: And this one we get, you know -- on

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the 6th it was evidently staffed, from what I see --
LOLA: The 7th because -- oh, sorry. I keep saying the -- no. The 7th because we -- I was on call with Shondra, and Shondra and I received that report. At 5:01 she got the phone call from the hospital that night.
LIEUTENANT MILLER: Uh-huh.
LOLA: And she called me and told me about it, and I sent her out to just go interview the family. And then we staffed that case on Monday morning and gave them the information and transferred it to Christa and Devondra because it was their assigned case.
LIEUTENANT MILLER: I guess -- and that's ten days ago is what I'm saying.
LOLA: Yes. Yes. Uh-huh.
LIEUTENANT MILLER: But anyway, I miss talking to you. I don't -- I don't see you enough.
LOLA: Yeah. It has been quite a while. It's like, shoot, I put -- put my phone on, but darn it, you would've called me today because I didn't, but I'm reaching for it right now to turn it on.
LIEUTENANT MILLER: Yeah. Well, I've called your cell phone, and you've told me that it wasn't working

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that good.
LOLA: Oh, it is now. They -- they -- she -- it's been fixed because they had gave -- given us new phones, and they had trouble with switching the phone line over or whatever -- however that works when you transfer to a new phone --
LIEUTENANT MILLER: Right.
LOLA: -- phone company. But it works now, unless my message still says it's not working. I didn't change it. I don't know. But it's working. I've been carrying it and turning it on.
LIEUTENANT MILLER: Well, that's good.
LOLA: Yeah.
LIEUTENANT MILLER: I'll have to start aggravating you some more now.
LOLA: I know. It's like, okay. All right. So --
LIEUTENANT MILLER: Well, anyway, like I say, I left a message for Christa to give me a call because we're just going to need to meet about this one so that we can figure out --
LOLA: Okay.
LIEUTENANT MILLER: -- you know, if there's anything else that needs to be done. We definitely need to find out what the uncle's deal is, who he is, you know, all that good stuff.

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LOLA: Yeah, because the uncle -- because Grandma is the one that pulled the nurse aside, I guess Friday -- Friday night -- well, 2 a.m. Saturday morning or whatever on Saturday Grandma told the nurse or the social worker that the uncle had been with the child too. It was the uncle and the dad.
LIEUTENANT MILLER: Uh-huh.
LOLA: So Grandma had some concerns about the uncle. And Shondra was saying to me, "How do I address that? Because he's saying" -- after she talked to him and then she came out and said, "Okay, Lola. He's saying he never had the child alone." And I gave her a different approach, and he did admit that -- then he did say, well, he was alone when the parents -- with the parents. But, yeah, he -- he -- later he changed his story. But Grandma had suspicions of the uncle.
LIEUTENANT MILLER: Uh-huh.
LOLA: So -- and we shared all our information with them -- with Christa and Devondra. We shared our information on Monday morning with what we had. And we told them, so we -- they knew about the uncle and everything and the information that the hospital had said so, yeah.
LIEUTENANT MILLER: Okay.

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LOLA: They -- they -- they should have it, and she should be interviewing him or talking to him. But, yeah, my understanding was they were (inaudible) could go ahead and do a law enforcement referral that day.
LIEUTENANT MILLER: Well, yeah, and I don't -- I'm easy as hell to get along with.
LOLA: Yeah.
LIEUTENANT MILLER: You know, and I -- if there's a problem or something, I'll -- and most of them call me. Y'all call me --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- you know, immediately and say -- but I haven't heard from Devondra on this one yet.
LOLA: Oh, wow.
LIEUTENANT MILLER: Everybody usually calls me and says, "Hey, I'm going to, you know, send this referral over." And by the time I can get to the fax machine, that's where it's at.
LOLA: It's there. Yeah.
LIEUTENANT MILLER: You know, but everybody usually gives me a heads up that it's coming, which they really don't need to do, but, you know, they can call me later and say, "Did you get it?" --
LOLA: Right.

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LIEUTENANT MILLER: -- because sometimes I don't get them, and they have to resend them.
LOLA: True. True.
LIEUTENANT MILLER: But -- and -- and if one's -- and if one's late, just give me a call and say, "Hey" --
LOLA: Yep.
LIEUTENANT MILLER: -- "you know, I'm going to get it to" --
LOLA: Yep.
LIEUTENANT MILLER: -- "I'm -- I'm going to let you know right now this is the names and stuff, but it's going to be a day or two before you actually get all the paperwork because I'm" --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- "trying to put something together." And I know y'all are busy. That's all they got to do is call me and tell me that instead of letting me find out ten days later that we had this with no phone calls.
LOLA: Yeah.
LIEUTENANT MILLER: Because I swear I don't want to get in -- you know, I ain't going to get nobody in trouble if I can damn help it.
LOLA: Right.
LIEUTENANT MILLER: But I may ask the wrong person about

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something one day and, you know --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- the next thing you --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- know your butt's on the chopping block.
LOLA: Yep. And consistency again. Not everybody on call is following up, making that referral to law enforcement. It's going to the caseworker the next day. "Here's what you're going to need to do: You're going to need to follow up with law enforcement and make your referral," because, if it does go to court, we don't need ten workers and, if one goes out there on call, puts the situation in place, makes sure things are safe and they're at the hospital, that's fine; they're safe. Next day the next person assigned the case needs to follow up, get with law enforcement, and they run with it.
LIEUTENANT MILLER: Yeah.
LOLA: So -- and then -- so that can go back and forth, back and forth on how that goes. But, heck, I'll be checking every darn report. For the county, we'll just go ahead and send you guys out there right off the bat so I don't have to have this conversation about why I didn't send her. Yep.

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LIEUTENANT MILLER: You know, and -- and --
LOLA: And then I don't want one like we had with Shaquita Gladden where they took the babies away from Daddy and you were out there on that case.
LIEUTENANT MILLER: Yeah. And I -- you know, and I understood, and I tried to explain to him what it was. I understood that to a -- you know, to a point. That wasn't -- I don't think that was a big deal. But my big deal was going to be -- is drawing that thing out after we'd done decided, you know, we wasn't going to keep that kid for no 45 days.
LOLA: Yeah.
LIEUTENANT MILLER: After about three days, we'd done figured out there wasn't nothing going to happen.
LOLA: Right.
LIEUTENANT MILLER: You know, that was bull.
LOLA: Yes. Yeah.
LIEUTENANT MILLER: But, yeah, no. I -- I -- I don't have a problem with taking or not taking -- well, I don't have a problem with taking children if we need to at that time --
LOLA: Right.
LIEUTENANT MILLER: -- just for safety's sake.
LOLA: Uh-huh.

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LIEUTENANT MILLER: But if -- if anybody thinks I'm going to back them up that two days from now we find out that there's nothing -- his story's valid and there was no problem there, it was an accident and all that kind of stuff, if they think I'm going to ride 45 days out with them on "just because" --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- they're wrong. I'm going to -- I'll switch to the other side in a minute and say, "Hey, you need to give these kids back." Just like I told -- told them.
LOLA: Yeah.
LIEUTENANT MILLER: You know, give these kids back. Let that man get back around these children. Hell, he didn't do that on purpose.
LOLA: Exactly.
LIEUTENANT MILLER: You know --
LOLA: Yeah.
LIEUTENANT MILLER: Now, I'll -- I'll go -- I'll go help you get one in a minute. In fact, I got one here -- the other one I was going to ask you about is Ashley Nicole Sigmond. We went out yesterday -- or day before yesterday to Hickory Grove Elementary School --
LOLA: Yes.

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LIEUTENANT MILLER: -- and met with Ashley Magwood.
LOLA: Okay.
LIEUTENANT MILLER: And they EPC'ed Ashley Sigmond.
LOLA: Okay.
LIEUTENANT MILLER: And I don't know why because I don't have any paperwork on that one either. If there -- and even if I need any.
LOLA: All right. Okay. Her super is Diane, and I know Diane's in the office. I think Ashley still is. So EPC'ed her on Wednesday, you said?
LIEUTENANT MILLER: Yeah.
LOLA: Last night?
LIEUTENANT MILLER: No. On the 15th.
LOLA: 15th. 15th.
LIEUTENANT MILLER: At 8:41 --
LOLA: Tuesday night.
LIEUTENANT MILLER: -- a.m.
LOLA: So they would've gone to court this morning, because it would've had to have had their probable cause hearing. Okay.
LIEUTENANT MILLER: This is patrol -- Mosley's the one went with them. But I just -- I was just wondering -- and it may not have anything to do with us.
LOLA: Uh-huh.
LIEUTENANT MILLER: But usually it's -- if y'all EPC

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one, there's definitely some legal or criminal ramifications somewhere, unless somebody's just so poor, you know, they can't help theirselves or something like that. I don't want to get involved in some of that stuff sometimes. But, you know, usually, if y'all EPC one, there's criminal -- possible criminal charges somewhere.

LOLA: And there was only the one child that was taken into care, W.J.?

LIEUTENANT MILLER: That's all I'm showing.

LOLA: Okay.

LIEUTENANT MILLER: Let me look.

LOLA: May have been a dirty house too. What -- what -- is it grandparents who have custody, or is it a mom and dad?

LIEUTENANT MILLER: Let me see here.

LOLA: I think that's the dirty house, and I think it's the -- there's two grandparents that have custody of them.

LIEUTENANT MILLER: I don't have parents' names on this report or nothing else. All I've got is "DSS York County" and "Ashley Nicole Sigmond who is 11 years old."

LOLA: And she might have --

LIEUTENANT MILLER: And her address in York -- I mean,

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in Sharon.

LOLA: Yep. She has a brother. That one is familiar. It is the grandparents who have -- it is the grandparents who have custody of her, and she has a sibling. And theirs was in reference to a filthy, deplorable environment, and the grandparents were told to correct that situation and, if they didn't, that DSS was added -- DSS was going to take action to get --

LIEUTENANT MILLER: Okay.

LOLA: -- them into care. So that -- that is over a home environment.

LIEUTENANT MILLER: Okay.

LOLA: That is a -- they're saying the home was in disarray, human feces on the floor.

LIEUTENANT MILLER: Human?

LOLA: Yeah.

LIEUTENANT MILLER: Geez.

LOLA: Full -- home full of clutter, had a foul odor. Grandma has a pot by her bed and uses it as a toilet, which it was terrible. Nine cats. Grandfather had to be transported to the hospital due to infection from the cats in the bed with him. Timothy poops on him -- has bowel movements on himself. And that's documented and that -- there

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is records on that.

LIEUTENANT MILLER: Hell, somebody needs to EPC him, it sounds like.

LOLA: Yeah. I don't understand why he wasn't brought in. Linda has one leg amputated, may have to have another one removed. Continues to be unkept and unsafe for the children. They were told to clean it. And I believe law enforcement, the first time, had given them the option and then said they would come back and follow up with the family, and DSS said the same thing. So that home did not -- the environment did not improve. So that is why the child --

LIEUTENANT MILLER: Where's Mama and Daddy?

LOLA: -- were taken. They're -- they don't have custody of the kids so they don't count anymore. Mommy and Daddy is Linda and -- let me get that. Linda and -- yeah. She's a -- Linda and who? Linda and Lanny.

LIEUTENANT MILLER: Linda and Lanny who? Sigmond?

LOLA: Sigmond. And Robert Sweeny was the dad and Lisa Rhodes was the mom, but they -- if I recall correctly, they were TPR'ed, so we don't count them. They're not -- they don't count anymore. They're not the parents.

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LIEUTENANT MILLER: Damn, if they're worse than the grandparents, geez.

LOLA: Yeah. Eh? And so we're -- I mean, it's the grandparents who are as the custodial parents.

LIEUTENANT MILLER: Yeah.

LOLA: They are the ones that are responsible for the children; they have them. And actually, both of them are in care. Yeah. Timothy and Ashley are both in care -- they are both in foster care.

LIEUTENANT MILLER: Okay. Well, I don't need to --

LOLA: Yeah. That -- that -- that was a deplorable home.

LIEUTENANT MILLER: Yeah.

LOLA: That was a very deplorable home.

LIEUTENANT MILLER: Well, there's no -- and -- and from what you've just told me, there's nothing -- you know, what are we going to do? Go lock them old people up? They've got enough damn problems of their own.

LOLA: I know. Yes. Yes.

LIEUTENANT MILLER: Yeah. But that's cool. We -- long as I don't get that one, that'll be fine.

LOLA: Yes.

LIEUTENANT MILLER: I just wanted to ask about it because I got it --

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LOLA: Yeah.
LIEUTENANT MILLER: -- in the reports this morning so --
LOLA: Yeah. So -- and, see, that -- see, those are -- those -- some of those ones where we do -- because the home environments show physical neglect and whether or not they can be charged. But, you know, they're old; they're -- and then, too, the court ends up throwing them out as a rule anyways, especially family court.
LIEUTENANT MILLER: Yeah. Okay.
LOLA: All right. So that works.
LIEUTENANT MILLER: That works. You're always a lot of help.
LOLA: All right. Great, and I will send law enforcement out there with every worker if it's York County.
LIEUTENANT MILLER: Do what? Say that again.
LOLA: I will be sending law enforcement out there with every worker when I'm on call if it's York County -- to the hospital.
LIEUTENANT MILLER: Now you know that ain't no good -- that ain't no -- the way I called you, girl. See, the only way I learn stuff is by asking questions.
LOLA: Uh-huh.
LIEUTENANT MILLER: And that's why I asked the question

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is why were we not called the night that the child went to the hospital.
LOLA: Yeah. Child --
LIEUTENANT MILLER: And with that background, see, that's --
LOLA: Yeah.
LIEUTENANT MILLER: This -- if -- if you listen to what I'm trying to tell you is, if Devondra would've called or sent this in eight days ago --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- we wouldn't be having this conversation right now --
LOLA: True.
LIEUTENANT MILLER: -- because somebody would've already been assigned it and it would've been all -- they would've already had a meeting, and we would've been done with this. Doesn't have anything to do with whether or not -- you had a reason not to call us --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- that night. I understand that. It's not you that got me to call you tonight and --
LOLA: No.
LIEUTENANT MILLER: -- and -- or to call you today --
LOLA: Today.

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LIEUTENANT MILLER: -- and question you on this stuff. It was Devondra --
LOLA: Right.
LIEUTENANT MILLER: -- for not doing it.
LOLA: Yeah. What happened?
LIEUTENANT MILLER: Right.
LOLA: Why the time lapse? Why the time lapse?
(Inaudible.)
LIEUTENANT MILLER: Yeah. Why is there a ten-day lapse between the time you were assigned it and I get it --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- and there's possible criminal, you know, charges here.
LOLA: Uh-huh.
LIEUTENANT MILLER: Not that she --
LOLA: Twenty-four hours.
LIEUTENANT MILLER: -- that they had been there four times -- you know, they'd been to the doctor four times, and finally, you know, the child's on the way out of here, I guess --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- and they grab her up and take her to the hospital and then they transfer her to Charlotte to Levine, which I love Levine. I don't

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know what nobody else does, but I love them.
LOLA: Yes.
LIEUTENANT MILLER: But they -- that -- that was my thing. And the question -- see, I didn't realize all that, and that's why I asked you those questions.
LOLA: Uh-huh.
LIEUTENANT MILLER: You know, and you have enough sense --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- to know whether to call us or not. I'm not questioning your ability by no means.
LOLA: Uh-huh.
LIEUTENANT MILLER: But, see, I didn't know any of that.
LOLA: Right.
LIEUTENANT MILLER: Because that -- that would've been my first question to Devondra is: "Why didn't we get called out that night?"
"And she'd have said, "Well, they've already taken her to the -- or taken him to the doctor four times, and the doctors kept saying that it's okay, you know, it's just bruises. And then, you know, this happens."
"Okay. Well, I understand that."
LOLA: Right.

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LIEUTENANT MILLER: That's why we didn't get called out, because they -- it was just -- you know, they really tried.
LOLA: Uh-huh.
LIEUTENANT MILLER: So don't take offense to that because that's not --
LOLA: No. I'm not going to. No, no.
LIEUTENANT MILLER: -- that's not what I said.
LOLA: Uh-huh.
LIEUTENANT MILLER: You know, nor is the --
LOLA: It's just the ten-day wait. What happened?
LIEUTENANT MILLER: Right.
LOLA: Yes. Yes. Yeah.
LIEUTENANT MILLER: So --
LOLA: Yeah, I can't answer. I don't -- I don't have the answer.
LIEUTENANT MILLER: Yeah. Well, we'll -- I'll deal with it. I'm -- you know, but like I say, there's no need in them -- if you got a problem with a case or something or you're -- you know, and I know y'all are covered up. There ain't no two ways about it.
LOLA: Uh-huh.
LIEUTENANT MILLER: Give me a call and let me know you're covered up, and just tell me what you going to send me.

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LOLA: Right. Okay. Yeah.
LIEUTENANT MILLER: You know, and if need be, hell, I'll come over there and fax it to myself, you know? If you don't have a lot, just give me whatever you can give me so we can get started with you. We're -- you know, we're --
LOLA: Exactly.
LIEUTENANT MILLER: -- supposed to work as a team. We're not supposed to be pulling away from each other.
LOLA: No. Exactly.
LIEUTENANT MILLER: So --
LOLA: That -- that's true. Yeah. And you know what surprises me too, though, is how come Levine's didn't call law enforcement because they've done -- they've been good that way too doing that.
LIEUTENANT MILLER: Yeah. I don't understand that either because we --
LOLA: She said they never called.
LIEUTENANT MILLER: -- got the call -- we got the call from Levine's when that little boy came up there with his broken arm.
LOLA: Yes.
LIEUTENANT MILLER: Or from Piedmont. Not -- not Levine's. But from -- Piedmont even called.

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LOLA: Yeah.
LIEUTENANT MILLER: Because --
LOLA: Yeah. It's like this one really fell through the cracks because nobody -- PMC didn't call law enforcement on that one, and then Levine's never called law enforcement. It's like, "Holy crap." It's like oh --
LIEUTENANT MILLER: Do y'all -- let me ask you this question too: How do y'all deal with DHEC? Do y'all want a -- never mind.
LOLA: Department of Health and Environmental Control?
LIEUTENANT MILLER: Yeah.
LOLA: We don't have too much dealings with them from a CPS perspective.
LIEUTENANT MILLER: I cannot get these people to understand that it is okay for a 14-year-old and a 16-year-old to have sex.
LOLA: Oh, I know. Because, remember, Lisa had that big meeting, and then she never did send out that letter. We have to wait till February when she'll send out that letter.
LIEUTENANT MILLER: Well, I told -- I've called this lady. She keeps sending these things over here with nobody's name or nothing on them.
LOLA: Oh, yeah because that's confidentiality, right?

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LIEUTENANT MILLER: Bull shit.
LOLA: Yeah. How you going to find your client if -- if she's --
LIEUTENANT MILLER: Oh, you've got to call them back and give them this client number; then they can tell you over a phone that could be tapped, you know?
LOLA: Right.
LIEUTENANT MILLER: And I'm sitting -- I'm sitting there going, "Ma'am, DSS and us fax stuff back and forth every day" --
LOLA: Yeah. You're law enforcement.
LIEUTENANT MILLER: -- "over children's names, their medical records. We -- I mean, we get all that stuff back and forth." I said, "And furthermore, this is not HIPAA."
LOLA: No. That's not. Not with law enforcement.
LIEUTENANT MILLER: Yeah. This is a law enforcement -- this -- I mean, it doesn't even -- this category does not even fall under HIPAA.
LOLA: No. No. Because there -- the law, too, says that any child victim of abuse, HIPAA does not apply.
LIEUTENANT MILLER: Right. And if -- and this is a crime --
LOLA: Yeah.

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LIEUTENANT MILLER: If you -- if you're sending it to me because you think it's a crime, it's not HIPAA-protected.
LOLA: Exactly. And that's in that PMC booklet too.
LIEUTENANT MILLER: I -- I do not know why DHEC can't -- and -- and I told her, I said, "Well, maybe -- maybe you're not the person I need to talk to. Who's your supervisor or the director?"
LOLA: Right.
LIEUTENANT MILLER: I said, "Hell, let's go all the way up to the top and talk to the director."
LOLA: That's right too. Because we get some from -- and I think it is DHEC -- Child Resource Development Center. They'll do that with us with when they're trying to send over a referral. And it's like, "How can we proceed if you don't have the -- can't give us the information, we can't take your intake."
LIEUTENANT MILLER: Yeah. This is --
LOLA: It is -- Katie -- Katie's a bad person to deal with.
LIEUTENANT MILLER: Well, I can't read this woman's name, which I -- if I was them, I wouldn't write my name on it either. I think Maloney or something like that. It's a nurse. But she sends it over,

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"Date of request" -- or it says, "Report of sexual activity of a minor under 16. 15-year-old" -- a girl that's 15 year old, 4 months, and 23 days is having sex with a 16-year-old.
LOLA: Oh.
LIEUTENANT MILLER: And I said -- and I said, "Did he rape her?"
LOLA: Right.
LIEUTENANT MILLER: "Well, no."
"Did he force her to have sex?"
"No."
"Are they having consensual sex?"
"Yeah."
I said, "That's not against the law."
LOLA: No.
LIEUTENANT MILLER: "Well, they changed the law."
I said, "Yeah. They changed it and dropped it a year."
LOLA: Uh-huh.
LIEUTENANT MILLER: I said, "A 14-year-old can have sex with another person that has not reached their 19th birthday yet."
LOLA: Yes.
LIEUTENANT MILLER: I said, "But here's the catch, now, if y'all want to send me one that's 15-year-old

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having sex with a 19-year-old, you feel free to do that, because that's against the law."
LOLA: Uh-huh.
LIEUTENANT MILLER: I said, "Now, it's ignorant, but it's against the law."
LOLA: Uh-huh.
LIEUTENANT MILLER: I said, "But don't send me any more of these people unless there is a charge of some sort of criminal act" --
LOLA: Right.
LIEUTENANT MILLER: -- "because a 14-year-old and a 16-year-old and a 15-year-old and a 17-year-old and all yada, yada, yada, as long as they haven't reached their 19th birthday, it's okay."
LOLA: So did they acknowledge what you were telling them?
LIEUTENANT MILLER: No. Hell, they sent me another one two days later. I'm going to start -- I'm going to get me a "Reject" stamp --
LOLA: Oh, cute.
LIEUTENANT MILLER: -- and I'm going to stamp it and send it back to them.
LOLA: I know because it's like people sometimes -- it's like, "What do you -- what do you not hear? It's not a crime. This is not a crime, so it's not

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something that goes to law enforcement."
LIEUTENANT MILLER: I -- I don't know. I -- it just drives me nuts. It's -- but --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- the actual crimes aren't going to be the ones that tick me off.
LOLA: Oh, exactly. Exactly. It's in --
LIEUTENANT MILLER: -- the bureaucracy and --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- bull shit that you have to put up with.
LOLA: Oh, yeah. Yeah. We -- we had a report today about a faint scratch and there's an open treatment case and it was indicated for physical neglect. And they were giving it to us as a new report for physical abuse. I said, "You know what? No. How about the treatment worker just go ahead and take a look at the situation, see if there is need for a new report." It's a faint scratch.
LIEUTENANT MILLER: And -
LOLA: You don't need to do a full-blown investigation.
LIEUTENANT MILLER: And how many different ways that could've happened?
LOLA: Yeah. That's what I said. I said, "Go find out if his cat scratched him. Can you -- can you find

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that out for me?" I mean, please, anybody can get scratched easily. A scratch -- a faint scratch, but kid said something about "whooping." Well, you know what? Treatment's in there. Treatment knows what's going on in the household. Go ask Mom, "Hey, are you actually whooping your kids? You told me that you weren't, but your child's saying that you do now. Is this true?" Unh-unh. I mean, we have, like, for -- for-your-information-only, like, markings that we can do with the report. If there's an open case already, we don't need to go back in there and do a new investigation on everything. It's like, "You go out there and tell us what you see. Is there concerns for something new? Then you can make a new report."

But we have counselors calling, "There's a faint scratch on him, and he says his mom whoops him." Okay.

LIEUTENANT MILLER: Yeah.

LOLA: Never seen bruises or marks but there's a faint scratch today.

LIEUTENANT MILLER: Yeah. That's just --

LOLA: Yeah. It's like you deal with some of the crap -- crap you get. And that's serious, still calling us from the hospital with the same thing --

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LIEUTENANT MILLER: Yeah.

LOLA: -- 15-year-old having sex with a 16-year-old. Okay.

LIEUTENANT MILLER: Yeah. Did he -- and my first thing is: Did he rape her or force her to have sex?

LOLA: See, and they're not. And -- and -- and Becky has a good relationship -- I think -- I forget who the woman is now -- with the social worker at the hospital who's calling and making the reports and that -- that social worker's saying, "No. But we were just told that we have to call you." It's like, okay.

LIEUTENANT MILLER: "Well, you called and you said it. Goodbye."

LOLA: Uh-huh. Uh-huh. We do, and you notice you're not getting them because we're not sending them to you. But we'll lie through our teeth if we have (inaudible).

LIEUTENANT MILLER: Girl, you ain't right. You're not right.

LOLA: Yeah.

LIEUTENANT MILLER: Well, it was sure good to talk to you.

LOLA: Yeah. You too.

LIEUTENANT MILLER: I -- I know you probably didn't, but

Page 47

I enjoyed it.

LOLA: Yeah. Are you taking some Christmas vacation here next week?

LIEUTENANT MILLER: No. I'm on call next week.

LOLA: Oh, wow. Okay. We're hoping it's quiet, right?

LIEUTENANT MILLER: Yep. Are you on call?

LOLA: Yeah. I have the 24th.

LIEUTENANT MILLER: Ooh, good.

LOLA: And I want a quiet -- well, I only have the one day, the 24th.

LIEUTENANT MILLER: Oh, hell, I got all next week.

LOLA: But I want it quiet.

LIEUTENANT MILLER: But I don't have to go unless my detective can't handle it.

LOLA: Oh, okay That's how you get up there then, eh?

LIEUTENANT MILLER: Yep.

LOLA: Oh, all right.

LIEUTENANT MILLER: (To unknown male) Huh? No I had more important shit to do besides iMapping. I hate I missed it.

UNKNOWN MALE: It was good.

LOLA: All right. Well, if I don't catch -- hear from you next week, you have a Merry Christmas.

LIEUTENANT MILLER: You do the same and have a safe one. And --

Page 48

LOLA: Yes.

LIEUTENANT MILLER: But if you need anything, you know who to call.

LOLA: Oh, yeah. And -- and --

LIEUTENANT MILLER: You've got my cell phone number.

LOLA: And I will not hesitate on the 24th at all if York County is needed and if there's a referral to law enforcement.

LIEUTENANT MILLER: You won't have to worry about it. You don't have to worry about it.

LOLA: All right.

LIEUTENANT MILLER: Well, you take care, and it was good talking to you.

LOLA: Same to you.

LIEUTENANT MILLER: All right.

LOLA: All right. Bye, W.J.

LIEUTENANT MILLER: Bye-bye. Bye-bye.

LOLA: All right.

(End of recording.)

(*This transcript may contain quoted material. Such material is reproduced as read or quoted by the speaker.)

(**Certificate accompanies sealed original only.)

EXHIBIT

"25"

DATE	TIME	RECORD PROGRESS OF CASE, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, AND INSTRUCTIONS TO PATIENT.
12/7/09		NSurg
	1000	Family reports he is tolerating po
		Chronic reflux - spitting c feeds.
		Parents have noticed drumming [illegible]
		uncertain if present from birth.
		Happy, active. MAE =
		10 prone position at [illegible]
		HC - 48.5 cm
		- will obtain HC graph from Peds office
		Dr. Baxter (803-980-7337)
		left message
		[signature]
		[signature] 12-2-10 1115
12-7-09		Neurosurg
1845		Alert. Doing well overall. Repeat
		CT shows stable extra-axial collections
		(R) denser than (L). OK to discharge
		under supervision — will need to
		see in f/u 2-3 weeks. Should be
		instructed prior to disch re: s/s of
		↑ICP.
		[signature]

ABBREVIATIONS	
USE	DO NOT USE
Units	u or U
International units	IU
X mg (Never use a trailing zero)	X.0 mg
0.X mg (Always use a leading zero)	.X mg
daily	QD
every other day	QOD
Morphine	MS or MSO4
Magnesium Sulfate	MgSO4

Carolinas HealthCare System
PROGRESS RECORD
(3/07)

09339-00393
C000545-02-19
[redacted],OWEN [redacted]
ATT PHY: 68247 CHIPS,TEAM A
12/06/09 DOB: [redacted]

EXHIBIT

"26"

Levine Children's Hospital | Specialty Centers

(704) 446-KIDS (5437) (888) 279-KIDS (5437)

PATIENT: C[redacted] Owen [redacted] HIST. NO: 000-545-02-19
Date of Birth: [redacted] ACC. NO: [redacted]

DISCHARGE SUMMARY

Children's Hospital Inpatient Service (CHIPS) team A

Date of Admission: 12/05/2009
Date of Discharge: 12/08/2009

Principal Diagnosis:
1. Subdural Hemorrhage

Hospital Course: This patient is a 2-month-old previously healthy Caucasian male who presented to the emergency department at Levine Children's Hospital from Piedmont with ALTE. The patient's parents report that around 1630 on Friday evening, the patient had an episode shortly after a feed, where he cried out and then arched his back. He went limp for approximately 10 minutes afterwards. There is no color change, no cyanosis, no loss of consciousness. The patient did not have any shaking or seizure-like movements at the time. Parents report that he was whimpering around with the 10 minutes mark and when he was removed from his car seat at the emergency department, he then cried and began acting more normally. They also reported that he has been more sleepy since that time and has been fussy but somewhat consolable. He was noted to have a minor cold about one week ago and what the parents describe as a throat infection. The patient in addition, today has had nonbloody, nonbilious vomiting that has been nonprojectile in nature after all feeds last evening. There is marked decrease in urine output and the patient has only had one wet diaper so far today as well as the urine that was obtained when he was catheterized. The patient received one dose of Rocephin at the outside hospital before being transferred here, after labs were obtained for a full sepsis workup.

Neuro: On admission, it was noted that the patient had a full fontanelle. A CT scan revealed a R sided subdural hemorrhage. During his stay here, he had no more ALTE-like episodes and acted like himself. He had a repeat CT scan which demonstrated no acute change.

CV: No tachycardia / bradycardia. Stable.

Pulm: The patient was satting well throughout the visit.

FEN/GI: The patient was on a regular age appropriate diet during his course here.

Renal: Following admission, the patient was making adequate urine.

Heme/ID: The patient's hemoglobin rose from 8.3 to 9.4. Stable otherwise. Low suspicion for infection.

Social: The patient was evaluated for NAT and received a normal ophtho examination & skeletal survey. Initially, there was some concern about the patient's distal R femur but images were re-checked and no fracture was seen. DEPARTMENT OF SOCIAL SERVICES & MEDICAL SOCIAL WORK were consulted. It was determined that the

family would attend parenting classes and DEPARTMENT OF SOCIAL SERVICES would evaluate the home situation.

Pertinent test results:
1. CT Scan Head (12/5): Thin falx subdural hematoma and right convexity subdural hematoma.
2. CT Scan Head (12/7): interhemispheric and right convexity blood
3. Skeletal Survey: Negative

Condition at Discharge: Good

Discharge Medications:
None

Instructions given to Patient/Family:
1. Please return in 2 weeks for repeat skeletal survey
2. Please pay close attention to baby and do not leave him alone or unattended
3. Please monitor for changes in mental status, increasing lethargy, onset of vomiting.

Follow-up Care:
Dr. Praxton at Sunshine Pediatrics (Primary Care)
LCH X-Ray for Skeletal Survey on 12/16/09

Thank you for allowing CHIPS to care for your patient at Levine Children's Hospital. If you need additional information, you may access the patient's electronic medical record or call the Pediatric Referral Line at 704-446-KIDS and ask to speak with the CHIPS attending for Team A.

D: ERIC SCHENFELD, MD/R
T: 12/08/2009 3:18 P es6
cc:

Routing
Pediatric Physician Link: Please route to all providers listed in Follow-up Care. In addition, route to ??

CMC (12.05.09) 004

EXHIBIT

"27"

A Shaken --
Q -- syndrome?
A That's what, yeah, correct.
Q Okay, okay. Is the absence of -- of a retinal hemorrhage, does that rule out that there is nonaccidental trauma?
A No, it wouldn't. I mean, it -- it just -- there's no way to --
Q Okay.
A No, it wouldn't, because, I mean, obviously, there would be, obviously, different ways to traumatize a child. I mean, it -- I mean, you could shake them here and it -- and their head might be stable for some reason. So they might not have retinal hemorrhages. But that obviously would be nonaccidental trauma.
Q All right. Well, have you ever had an occasion to evaluate a child who -- who was suspected of suffering from nonaccidental trauma and had subdural hematomas but did not have retinal hemorrhages?
A To my recollection, I've seen children who've had subdural hematomas who didn't have retinal hemorrhages. But I don't know. And again, it -- it -- it comes with, you know, my role is

EXHIBIT

"28"

Attachment F

Child Abuse and Neglect Algorithm

Medical team identifies child in whom abuse or neglect is suspected

↓

Consult CHS Clinical Care Management Social Worker to assist with assessment process

↓

Is the suspicion of abuse or neglect confirmed

Yes → ↓

Report case to:
- County DSS in which child resides
- Law Enforcement Agency where the incident occurred, if indicated

↓

Complete SCAN Form including diagrams

↓

Investigating agencies to provide evidentiary photography and maintain chain of custody

↓

Refer to Administrative Policy # PR120.06 "Consent for Treatment" if parent guardian, custodian, or caretaker refuses to authorize necessary medical treatment for child

↓

For patients with evidence of acute multi-system injury consult CMC Trauma Service at 1-800-421-9195. If patient is at CMC contact Trauma Chief at pager 1888 or the Trauma Attending at pager 1899

↓

Consult LCH Pediatrics at 704-446-5437 or 1-888-279-5437 for assistance with medical management For patients at LCH contact the Hospitalist at pager 7415

→ Refer to Child Maltreatment Clinical Practice Guidelines (policy PR110.03) for assistance with medical management

→ When medically cleared, do not discharge child until disposition has been determined by medical-social worker and DSS

No → ↓

Continue with Medical Management Plan
Provide safety education as indicated

EXHIBIT

"29"

Order No.	Time	Date	Room	Entered By	Priority	Scan / Faxed Complete	Initials / Signature
	0350	12-5-09	8015-01		☐ STAT ☐ Normal		

Admit to CHIPS A Attg: Gall Intern: Schaufeld x 1360
Dx: ALTE
Condition: Good wt = 6.1 kg
Vitals: Q4°
Activity: Astolerated Falls precaution Reflux precautions
Allergies: NKDA
Nursing: ABD monitors Q4° neuro checks Strict I/Os Daily wt
Diet: PO ad lib on demand
IVF: ~~5% NS~~ NS bolus 120 ml IV x 1 now then D5 ~~1~~ NS @ 25 ml/hr
Add 20 mEq KCl/L p 1st void
Meds: None
Labs: Viral DFA

CHART CHECK
Date _____ Time _____
RN Signature _____

A. RG MD
Renfrow
x6423

Order No.	Time	Date	Room	Entered By	Priority	Scan / Faxed Complete	Initials / Signature
	0821	12-5-09			☐ STAT ☐ Normal		

STAT CT Head w/o contrast R/o bleed

A. RG MD
Renfrow
x6423

ABBREVIATIONS	
USE	QD QOD
units	U IU
International units	U IU
X mg (Never use a trailing zero)	X.0 mg
.X mg (Always use a leading zero)	.X mg
daily	QD
every other day	QOD
Morphine	MS MSO4
Magnesium Sulfate	MgSO4

Carolinas HealthCare System
PHYSICIAN'S ORDERS

4844 (9/05)

PATIENT LABEL

09339-00393
C000546-02-19 LV:
C[redacted],OWEN[redacted]
ATT PHY: 99026 CMCED,PEDS
12/05/09 02:14A DOB: [redacted] TCC

Rainey-Carduff v. Carolinas Medical Center
000030

PLAINTIFF'S EXHIBIT 29 RC 9/30/14

EXHIBIT 29

General Progress Note

Carolinas Medical Center — Printed: Monday, DEC 07, 2009, 12:03 by COURTLANDT , CHERYL DENISE MD

RM: 8023, SPC — C[redacted] OWEN [redacted] — 2 MO (DOB: [redacted]) M — MRN: 5450219

Attending: CHIPS , TEAM A — Code Status: None Specified — Reason for Admission: ALTE

Service: PED - Pediatrics

Allergies: , No known allergies

Vitals	Temp	BP	Pulse	RR	SpO2	FIO2/O2
12/07 10:00	----	66/54	154	28	98	RA
12/07 06:30	----	-----	132	29	---	RA
12/07 05:30	----	-----	115	23	---	RA
12/07 04:30	----	-----	134	24	---	RA
12/07 03:30	----	-----	130	25	---	RA

Date	Wt(kg)	Wt(lb)
12/07	6.0	13
12/07	6.0	13
12/06	6.0	13
12/05	6.1	13
12/05	6.1	13

	Recorded Input		Output	Balance
12/07	7a-3p	120	121	-1
	3p-11p	---	---	---
	11p-7a	---	---	---
	24 Total	120	121	-1
12/06	7a-3p	270	203	67
	3p-11p	150	193	-43
	11p-7a	270	109	161
	24 Total	690	505	185

24 Hr Tmax: 97.9 at 12/06 19:30
36 Hr Tmax: 97.9 at 12/06 19:30

Vitals Signs are the last 5 in the past 48 hours.
Weights display the last 5 within 7 days.
Clinical Wt: 12/07 6.1 kg 13 lb

Active Inpatient Medications: — Continuous Infusions:

Labs: Results shown are for the past 8 hours

12/07 0639								
HCT	28	L	MCH	28		RBC	3.34	L
HGB	9.4	L	MCV	84		RDW	13.6	
			Platelet	523	H	WBC	10.1	

Notes:

Date:

Time:

Redo attending note
pt clinically well
but AF, slightly bulging ?HC↑
MS-unchanged
eye exam ⊖ NAT ⊖
Child Coordinator/MSW involved
parents updated

HEENT- large appearing head
post fontanelle
AF - very full
Lungs - clear
Heart - RR on Abd - benign
Impression - Subdural
hematoma
normal MS @ this time
Plan: repeat CT 20 AF

Signature: CCourtlandt MD 12/7/2009 10 m — Date/Time

Physician Progress Note

333

☐ ADMITTING
☒ ATTENDING
☐ CONSULT

ACCT: 0933900393 MRN: 0005450219
C[redacted] OWEN [redacted]
ATT PHY: CHIPS , TEAM A
12/05/09 04:45A DOB: [redacted] 2 MO

VW MSW about D/C planning
V DSS referral status

PAGE BREAK]

Rainey-Carduff v. Carolinas Medical Center
000036

Physician Progress Note

Carolinas Medical Center — Printed: Tuesday, DEC 08, 2009, 07:08 by SCHENFELD, ERIC MD

RM: 6023, 8PC C[redacted] OWEN[redacted] 2 MO (DOB[redacted] M MRN: 0005450219 Acct: 09339-00393

CURRENT PROBLEMS:

NOTES/PLAN: Peds attending
Note
extensive conversation w/ Dr. Morgan-Glenn,
MSW regarding case
neurology of sub dural revealed
NAT (w/ Flu ⊖), eye exam ⊖
no story pertaining an explanation

HEENT-AF ↓
Lung-clear
Heart-RR sm
Abd-benign.
Impression-Subdural
hematoma
? etiology
NAT ⊖ @ this time
Plan-DSS to follow
family w/ home
visits, supervision
cleared by MSW
Repeat skeletal
survey 2 weeks
Flu w/ PCP

ATTENDING NOTES:

Signature: [signature] 12/8/2009 12m

Physician Progress Note

☐ ADMITTING
☒ ATTENDING
☐ CONSULT

ACCT: 0933900393 MRN: 0005450219
C[redacted], OWEN[redacted]
ATT PHY: CHIPS, TEAM A
12/05/09 04:45A DOB:[redacted] 2 MO

Rainey-Carduff v. Carolinas Medical Center
000033

EXHIBIT

"30"

DATE	TIME	RECORD PROGRESS OF CASE, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, AND INSTRUCTIONS TO PATIENT.
1815 12/7/09		X-cov',
		Pt w/ stable CT. DSS/SW
		ok to D/C w/ Mom & Dad
		Will D/C home, F/U w/
		Dr. Baxter (PCP). Will D/W
		NSG & follow their recs
12.8.09		Neurosurg –
	0815	Alert [illegible]. AF soft. HC 42.5
		OK c̄ me to discharge
		[signature]

ABBREVIATIONS	
USE	DO NOT USE
Units	u or U
International units	IU
X mg (Never use a trailing zero)	X.0 mg
0.X mg (Always use a leading zero)	.X mg
daily	QD
every other day	QOD
Morphine	MS or MSO_4
Magnesium Sulfate	$MgSO_4$

Carolinas HealthCare System
PROGRESS RECORD
(3/07)

09339-00393
C000545-02-19
C[redacted],OWEN [redacted]
ATT PHY: 66247 CHIPS,TEAM A
12/05/09 DOB: [redacted] M 2M

EXHIBIT

"31"

Order No.	Time	Date	Room	Entered By	Priority	Scan / Faxed Complete	Initials / Signature
	2200	12/7/09	8093		☐ STAT ☐ Normal		

— D/C monitors while awake —
— resume while sleeping
(spot ∨ O_2)

FO Dr Melissa Smith / [signature]

DATE: TIME:

Estill 12/8/09 0752 MD SIGNATURE:

24° chart ✓ [signature] RN

12° chart check S MW / [signature] RN

Order No.	Time	Date	Room	Entered By	Priority	Scan / Faxed Complete	Initials / Signature
	0930	12/8/09			☐ STAT ☐ Normal		

1. D/c home ☥ parents ☥ MSW approval
2. Activity as tolerated
3. meds see med rec
4. f/u please schedule PNL ☥ Sunshine Peds 12/10 OV 12/11
   ✓ ☥ Radiology in 2wks for NAT (from admission (12/4/09)
5. D/c i.v.

Appointment
704-512-2060
12-18-09
9:00 AM
Levine Children's Hospital

1-803-980-7337
Appointment
Dec 11, 2009
at 8:45 am

[signature] MD Nugent #0789

FAXED 1117

1045817 confirmation #

fax no. 704-446-4100

ABBREVIATIONS	
USE	DO NOT USE
units	u or U
international units	IU
X mg (Never use a trailing zero)	X.0 mg
0.X mg (Always use a leading zero)	.X mg
daily	QD
every other day	QOD
Morphine	MS or MSO4
Magnesium Sulfate	MgSO4

Carolinas HealthCare System
PHYSICIAN'S ORDERS

PATIENT LABEL

09339-00393
C000545-02-10
C[redacted],OWEN [redacted]
ATT-RHY: 60247 CHIPS,TEAM A
12/05/09 DOB: [redacted]

"444"

Rainey-Carduff v. Carolinas Medical Center
4844 (9/08) 000018

PLAINTIFF'S EXHIBIT 34 9/21/11

EXHIBIT 31

EXHIBIT

"32"

PLAINTIFF'S EXHIBIT 25

PROGRESS NOTE -- CHILDREN'S HOSPITAL INPATIENT SERVICE HD#

DATE: TIME: Please see attached record of vital signs, medications, and laboratory data.

Patient / Family concerns:

General Appearance:

	Describe abnormalities as needed
HEENT	
☑ normocephalic	☐ head abnormal
	☐ conjunctival injection / icterus
☐ PERRL	☐ pupils abnormal / photophobia
☐ ears normal	☐ external canal abn (R / L)
	☐ TM abnormal (R / L)
☐ nasal mucosa normal	☐ mucosa abnormal
☐ oropharynx normal	☐ dry mucosa ☐ ulcers / vesicles
fontanelle flat	☐ pharyngeal erythema
	☐ tonsillar enlargement / exudate
NECK / LYMPH NODES	
☑ supple / no masses	☐
☐ no node enlargement	☐ enlarged cervical / axillary / inguinal
LUNGS / CHEST	☐ stridor
☑ no respiratory distress	☐ retractions / accessory muscle use
☑ breath sounds normal	☐ prolonged exhalation
	☐ decreased air movement
	☐ wheezing / crackles / rhonchi
☑ normal shape	☐ pectus (carinatum / excavatum)
CARDIOVASCULAR	
☑ regular rate & rhythm	☐ abnormal rate & rhythm
☑ heart sounds normal	☐ murmur grade ___/6 systolic/diastolic
☐ strong peripheral pulses	☐ pulses abnormal
☑ capillary refill normal	☐ delayed

GI (Abdomen)	Describe abnormalities as needed
☑ nontender	☐ tenderness / rebound / guarding
☑ nondistended	☐ distended
☑ no organomegaly	☐ hepatomegaly / splenomegaly / mass
☐ normal bowel sounds	☐ decreased / hyperactive
☐ anus/rectum normal	☐ abnormal
GU	
☐ external genitalia nl	☐ erythema / discharge / swelling / tender
EXTREMITIES	
☑ no swelling	☐ swelling
☑ nontender	☐ tenderness
☑ ROM normal	☐ abnormal
SKIN	
☑ normal inspection	☐ cyanosis / pallor / jaundice
☑ warm, dry, nl palpation	☐ cool / diaphoresis
☑ no rash	☐ rash
NEUROLOGIC / PSYCHIATRIC	
☐ mental status normal	☐ lethargic / confused / agitated
☐ cranial nerves II-XII nl	☐ CN deficit
☐ muscle strength/tone nl	☐ weakness
☐ sensation normal	☐ sensory deficit
☐ DTRs normal	☐ abnormal DTR
☐ cerebellar function nl	☐ ataxia
☐ age-appropriate gait	☐ gait abnormal
☐ mood & affect normal	☐ abnormal

ADDITIONAL FINDINGS:

ASSESSMENT / PLAN:

2 mo old ♂ w/ hx of Imp ALTE & increased irritability here w/ (R) SDH concerning for NAT & (-) w/u thus far.

(1) Neuro: stable - fontanelle normal today

(2) Cv/Resp: stable

(3) Social: (P) SW ok, pt ok to dc.

- f/u 2wks NAT
- parenting class
- home visit

☐ Discussed impression and plan with patient/family; questions answered and understanding of plan demonstrated.

SIGN / PRINT NAME Endrit Cost PAGER 6782

ATTENDING NOTE: I have examined & discussed this patient with Dr. I agree with the findings / plan as documented in the resident's note.

DATE ____ TIME ____

SIGN / PRINT NAME

Carolinas HealthCare System
PROGRESS RECORD

NAME
MR #

EXHIBIT 32 463

CMC (12.05.09) 0031

EXHIBIT

"33"

Page 1

Transcript of Recording
Labeled "Christa DSS"
Dated 1/19/2010

- - - - - - - - - - - - - -

Transcribed by: Audrey S. Beebe,
Southern Reporting, Inc.

Page 2

LIEUTENANT MILLER: Sheriff's office. Miller.
CHRISTA: Yes. Can I speak with Lieutenant Miller, please?
LIEUTENANT MILLER: This is him.
CHRISTA: Hey. I didn't catch your -- I was making sure it was you. How are you doing this morning? This is Christa.
LIEUTENANT MILLER: Hey. I'm doing good. How you doing?
CHRISTA: I'm doing pretty good. Did you get the news from the hospital?
LIEUTENANT MILLER: Unh-unh.
CHRISTA: The parents have decided to kind of just withdraw all care and just let the baby die. That's what Mom and the grandmother have decided.
LIEUTENANT MILLER: Well, did they not take it off the life support yesterday?
CHRISTA: Yeah, they did. They took him off the ventilator. So basically they're just -- they got the do-not-resuscitate in place.
LIEUTENANT MILLER: Okay.
CHRISTA: And based on the information that the doctors have given them that the baby is not going to get any better and he's going to be brain dead, they have decided to proceed that way. And the hospital

Page 3

has contacted us to let us know that, which we were made aware of that yesterday. But I knew since it was a holiday no one had contacted you.
LIEUTENANT MILLER: Right. Well, I appreciate that.
CHRISTA: Okay. I just had a couple of questions for you, Lieutenant Miller. Do you think we can schedule a meeting possibly? You and Amanda Carter so that we can sit down with Yvonne and Phyllis and myself and staff the case?
LIEUTENANT MILLER: Yeah.
CHRISTA: Just to make sure we're on the same page?
LIEUTENANT MILLER: Yeah.
CHRISTA: What about -- do you think Thursday? Can you check with Amanda and see? Or what do y'all have scheduled for Thursday?
LIEUTENANT MILLER: We've got a SART meeting at nine o'clock that morning.
CHRISTA: Yeah, I know. Lynn's going to that, so I'm aware of that. And we've got a meeting from 9:30 to 11:30, but we were looking at possibly the afternoon.
LIEUTENANT MILLER: Two o'clock?
CHRISTA: Two o'clock will be good.
LIEUTENANT MILLER: Okay. I better put that --
CHRISTA: And you think Amanda -- that might work in her

Page 4

schedule?
LIEUTENANT MILLER: Yeah. I'll get it in there unless there's a problem.
CHRISTA: Okay. Do you -- are you going to -- y'all want us to come there? You want to come here? How you want to do it?
LIEUTENANT MILLER: If y'all don't mind coming here, we've got -- probably got more room.
CHRISTA: That's fine. We can come there if you would like. Because it's going to be our attorney, our director, myself, program coordinator, and Devondra.
LIEUTENANT MILLER: Okay. Yeah. There's --
CHRISTA: So --
LIEUTENANT MILLER: I don't see a problem with that.
CHRISTA: Okay. So we can come over there. Also, did you ever check in that file to see the date on that info that I faxed you? You remember when I faxed you that dictation?
LIEUTENANT MILLER: Yeah. Hold on. I got it right here in front of me.
CHRISTA: I just want to get the date that you received the referral. I just want to make sure that --
LIEUTENANT MILLER: The 17th.
CHRISTA: The 17th?

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LIEUTENANT MILLER: 12/17/09.
CHRISTA: And then that was the day that I faxed you the dictation?
LIEUTENANT MILLER: Yep.
CHRISTA: Okay. Because I remember us talking. It was in the afternoon. Do you have a time on that? I know it was two or three o'clock, it seemed like.
LIEUTENANT MILLER: One of them -- the one that you sent me came at 1604, which would've been 4:04.
CHRISTA: Okay.
LIEUTENANT MILLER: And the other one was sent after hours on the 16th.
CHRISTA: The -- her referral?
LIEUTENANT MILLER: Yeah. It came in at almost seven o'clock on the 16th.
CHRISTA: Okay. That's what I was thinking. Those are the --
LIEUTENANT MILLER: Yeah.
CHRISTA: That's about the times that I had that I was thinking. Because she -- she doesn't have the -- the fax cover sheet in her case file no longer that -- where I faxed you the dictation. So I --
LIEUTENANT MILLER: Uh-huh.
CHRISTA: -- figured you would have it, so I just wanted to get that from you.

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On the day that you got the referral from me, I remember us talking about it. Did you ever call the hospital and verify any of what I told you? Or did you -- because I had faxed you over everything that they had told me.
LIEUTENANT MILLER: No. I didn't -- I didn't feel like I needed to do that.
CHRISTA: Okay. I -- I -- I didn't think --
LIEUTENANT MILLER: You've never --
CHRISTA: I -- they --
LIEUTENANT MILLER: You've never told me anything wrong so far.
CHRISTA: I know.
LIEUTENANT MILLER: Why would I do that?
CHRISTA: I -- no. They just asked me that, and I told them I did not think so because I had faxed over all of that information.
LIEUTENANT MILLER: Yeah.
CHRISTA: Okay. And it wasn't until the second report that you guys actually went out and met with them because we --
LIEUTENANT MILLER: Right.
CHRISTA: -- didn't have any concerns at the initial report.
LIEUTENANT MILLER: That's what -- you know, and that's

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why -- you know, after all that talking to everybody, there was no concerns. You know, and the -- and the thing was set up to do the in-home -- you know, the parenting counseling.
CHRISTA: Yeah. And I --
LIEUTENANT MILLER: So that's why I didn't -- you know, there was no more. I said -- you know, I'm -- to me that would've been slapping you in the face and calling you a liar and you don't know what you're doing, you know?
CHRISTA: Oh, I know.
LIEUTENANT MILLER: And I just -- I just -- that was my thoughts at that time, and that's, you know, still what I believe, that, you know, I don't think at that time we had a problem.
CHRISTA: Okay.
LIEUTENANT MILLER: You know, and that -- because I -- I -- I -- I believed what you said, and I know you believed what you told me. So --
CHRISTA: Oh, I did.
LIEUTENANT MILLER: You know, we can't -- nobody has a crystal ball around here so --
CHRISTA: I wish we did. It would make our jobs a lot easier, wouldn't it?
LIEUTENANT MILLER: They wouldn't need very many of us.

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Well, we don't --
CHRISTA: We might not have a job if we had a crystal ball, huh?
LIEUTENANT MILLER: All we'd need is one person with a crystal ball and the other one to chase it down, so --
CHRISTA: Uh-huh.
LIEUTENANT MILLER: But, no, I just -- that was -- that was my beliefs and --
CHRISTA: Yeah. What about Kayla? Are y'all -- are y'all still investigating her? She just acts so suspicious, Lieutenant Miller.
LIEUTENANT MILLER: We're not through. We're not through with this at all.
CHRISTA: Okay.
LIEUTENANT MILLER: No. We're not through with this at all. We just -- we're -- what we've done is we took -- taking a step back to let her go on and do what she needs to do as far as the child goes. But once -- once everything's said and done, she's going to come back into the picture.
CHRISTA: Because she probably thinks she's out of it.
LIEUTENANT MILLER: Right. I don't -- like I say, I don't know what part, if any, she has in it, but she's just --

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CHRISTA: She just is --
LIEUTENANT MILLER: -- she's just kind of weird-acting.
CHRISTA: And -- you know, and the -- then when they took -- I know the hospital -- this had come from the supervisor that was on call. The hospital had said, when they took the baby off of the ventilator, the baby gasped for air. And Mom was in the room, and she didn't really seem to be -- I mean, she's just kind of emotionless when it comes to a lot of things. And she's just very immature. I know that she's young, but she had -- I know she made that statement to you about the big -- big jail or the little jail.
LIEUTENANT MILLER: Yeah. You know, I'm sitting there going, Where -- where is this coming from and why are you even here?
CHRISTA: Yeah, I know. And she was -- and that's the thing. Because we had come -- when we went to the hospital, we're like, "Where is she?" And she's out running around dealing with Michael, and she's not -- I mean, she seems to be putting him before her child.
LIEUTENANT MILLER: Right.
CHRISTA: Yeah. And did he ever admit to shaking the baby in December?

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LIEUTENANT MILLER: No. He -- he said that didn't -- there wasn't anything -- nothing like that done, because I went back and talked to him. And he said that he didn't do -- there was nothing, and nobody could figure out what was wrong with him, other than him having a cold and a sore throat.
CHRISTA: But he didn't -- he didn't indicate that he had done anything --
LIEUTENANT MILLER: Unh-unh. No.
CHRISTA: -- to the baby in December?
Did y'all give -- y'all gave him a polygraph, didn't you?
LIEUTENANT MILLER: Yeah.
CHRISTA: And when -- did you ask him that -- was that question asked to him about --
LIEUTENANT MILLER: We did -- the only thing that we worked on him was with the --
CHRISTA: I know y'all were just trying to get him --
LIEUTENANT MILLER: -- current -- the current one, yeah.
CHRISTA: Y'all were just trying to get him to confess --
LIEUTENANT MILLER: Right.
CHRISTA: -- as quickly as possible. I know.
LIEUTENANT MILLER: Yeah. We got them. We got -- you know, he told us the truth. He told us a couple

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stories to start off with, but he told us the truth at the end.
CHRISTA: At the end?
LIEUTENANT MILLER: Yeah.
CHRISTA: So the polygraph indicated that he was --
LIEUTENANT MILLER: -- deceptive.
CHRISTA: Yeah. Okay.
LIEUTENANT MILLER: But we didn't bring up any -- there was nothing done about the -- the December stuff. Again, because that -- see, even -- even then that had not figured into my -- that had not even come back to -- in my realm of thinking --
CHRISTA: Oh, I know.
LIEUTENANT MILLER: -- as far as the December stuff because as -- talking with y'all, I had cleared that out of my head as far as -- because Lola even said, "Oh. This is the one that we had the report on back in December." She had to ring my bell on it, because I did not remember it because, once I had talked to y'all, that was said and done. That was -- that was a problem that was being, you know, taken care of. So I didn't even --
CHRISTA: Yeah. I didn't either. I mean, it's kind of a shock that any of this really happened because I never had any indication, and I'm all about taking

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babies and relatively placing babies. But the hospital just wasn't -- they weren't giving us any indication that they -- they had any real concerns.
LIEUTENANT MILLER: And all --
CHRISTA: You know, all the scans were negative and all -- you know, all those things that would indicate that the baby had been shaken. They didn't have any --
LIEUTENANT MILLER: And they had taken this child to four different doctors, and the only thing they came up with was a cold and a sore throat.
CHRISTA: Uh-huh.
LIEUTENANT MILLER: You know, and it's not --
CHRISTA: And I -- I have all their medical records, and it is consistent. They did take the -- the child to the doctors when they said that they had taken the child to the doctors.
LIEUTENANT MILLER: Right. I don't -- along with that and what y'all had told me and all that kind of stuff, I just -- you know, I felt comfortable with it, you know.
CHRISTA: Yeah.
LIEUTENANT MILLER: Maybe I shouldn't have, but --
CHRISTA: Well, I mean --
LIEUTENANT MILLER: -- I was comfortable.

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CHRISTA: Now you -- now it's easy to say that, but then, based on the -- because, you know, I had staffed it with our legal department, and we just didn't really have enough to do -- you know, proceed any further with doing a removal or anything.
LIEUTENANT MILLER: Right.
CHRISTA: So, yeah --
LIEUTENANT MILLER: Well, I think --
CHRISTA: -- it's unfortunate.
LIEUTENANT MILLER: -- it goes back to -- I -- I didn't even see that stuff that the grandfather or whoever it was said, but, you know, they need to -- people need to realize, you need to blame the person who did it.
CHRISTA: Yeah. And they're not --
LIEUTENANT MILLER: And he --
CHRISTA: The grandparents -- and I saw their little thing on Channel 9 News and all of that, but the thing is they need to think -- they had all these concerns and all these -- they have seen these mysterious bruises, and then he even went as far as to photograph a bruise on the child at some point. See, we weren't made aware of any of that.
LIEUTENANT MILLER: Right.

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CHRISTA: See, they should've been calling and making a report to us, had they -- had they had concerns. See, we could've looked at it a lot differently, and they were saying how, you know, that they were acting suspicious and Kayla had called one day and made a remark that she was going to lose it, to come get the baby. And -- yeah. So they didn't tell any of this to us until afterwards.
LIEUTENANT MILLER: Yeah. And, see, none of that came to light till after the -- the --
CHRISTA: Yeah.
LIEUTENANT MILLER: -- actual shaking of the baby that we know about.
CHRISTA: Yeah, I know.
LIEUTENANT MILLER: So --
CHRISTA: And --
LIEUTENANT MILLER: And, see, you're telling me stuff, again, that they're saying that I hadn't even heard yet.
CHRISTA: Yeah.
LIEUTENANT MILLER: So --
CHRISTA: Yeah. We'll -- we'll -- we'll get all that out there whenever we staff the case on Thursday because I just want -- I just want everybody to be on the same page, and let's just do a staffing and

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that way y'all can -- y'all have all the information that we have and we have what you have. And if you need copies of medical records or anything that we have, we can certainly provide you with all of those because the baby has beaucoup medical records.
LIEUTENANT MILLER: Okay.
CHRISTA: Tons. So you said two o'clock on Thursday afternoon?
LIEUTENANT MILLER: That'll be fine with me.
CHRISTA: Okay.
LIEUTENANT MILLER: Y'all just come over here and holler for me. We'll meet in one of our conference rooms.
CHRISTA: Okay. Thank you so much, Lieutenant Miller.
LIEUTENANT MILLER: Oh, and before you get off the phone, I called you earlier. I don't know if you were returning my call.
CHRISTA: No. I hadn't -- I hadn't checked any voice mails.
LIEUTENANT MILLER: Yeah. I'd left you one. The other one that I wanted to ask you about was this Kylie Sanders.
CHRISTA: Yeah.
LIEUTENANT MILLER: What's the deal with it? Have -- has she seen the SANE nurse yet?

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CHRISTA: Okay. She went to the pediatric doctor, and basically the pediatric -- see, okay, when I talked with Gina -- remember, you put me in contact with Gina?
LIEUTENANT MILLER: Right.
CHRISTA: Gina consulted with Dr. Olga Rosa in Columbia.
LIEUTENANT MILLER: Right.
CHRISTA: And their recommendation was that -- the general practitioner who had seen Kylie at Clover Family Medicine couldn't determine whether or not the child had a skin tag or had an anal wart.
LIEUTENANT MILLER: Right.
CHRISTA: And basically, Gina and Dr. Olga Rosa said that the doctor should've been able to determine that.
LIEUTENANT MILLER: Right.
CHRISTA: And their recommendation was that the child be seen by a pediatrician. So the foster parent took the child to Rock Hill Pediatrics, because I had Clover Family Medicine do a referral. And I have around here somewhere -- and I will send it to you. Oh, here it is. I'm going to send it to you -- where she saw the doctor on the 21st and they determined that the child had anal fissures that had been -- that were healed and they really

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couldn't determine whether or not the child had been sexually abused or not. We have this case down to staff it with David tomorrow to see what direction we're going to take.
LIEUTENANT MILLER: Uh-huh.
CHRISTA: They just couldn't -- they just -- they can't really tell you that -- just the child had anal fissures, and it healed. And it could be sexual abuse; it could not. They -- it could've went either way.
LIEUTENANT MILLER: Right.
CHRISTA: And this child, obviously, based on her age, she's nonverbal --
LIEUTENANT MILLER: Right.
CHRISTA: -- so we're not able to get any, you know, additional information. So we're going to be staffing it tomorrow. We've actually already indicated our case, but it wasn't for sexual abuse. But if they determine that we need to take a new report and do a new investigation in regards to these anal fissures, we -- we certainly will. And I'll -- and I'm going to give it back to Devondra if -- if that happens. But basically, that's all the information that I have at this time. And after I staff it tomorrow, I can give you -- and

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see what all foster care -- you know, if they have any additional information, I will call you tomorrow.
LIEUTENANT MILLER: Okay.
CHRISTA: I'll go ahead and fax this -- do you want me to go ahead and fax the visit over to you?
LIEUTENANT MILLER: Yeah. Go ahead and do that, and then let me know what y'all come out of -- what the outcome is from y'all's, because if it's not going to be -- you know, if -- if -- again, like, say we can't interview the child and we have to go off of doctors' records but they can't tell us either, the only person that would be able to tell us would be the grandfather, if he is the one that actually did it.
CHRISTA: And I don't know --
LIEUTENANT MILLER: And I don't know --
CHRISTA: And I'm going to tell you this child has been in contact with so many people, Lieutenant Miller, it'd be really hard to determine who -- who would even be a perpetrator. And that's the unfortunate thing is -- is her age.
LIEUTENANT MILLER: Who is the grandfather?
CHRISTA: I would have to get that information from Devondra.

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LIEUTENANT MILLER: Well, because -- is he a sex offender or --
CHRISTA: I think so, yeah. From my -- from my knowledge, he is a registered sex offender.
LIEUTENANT MILLER: Okay. Just get all that information for me so I can follow through on this side and see what we need to do and --
CHRISTA: I sure will.
LIEUTENANT MILLER: -- we'll --
CHRISTA: As soon as I get this Carduff squared away, just give me -- I -- I should have this to you in about an hour.
LIEUTENANT MILLER: Okay. That'll be great.
CHRISTA: Okay?
LIEUTENANT MILLER: Thank you, ma'am.
CHRISTA: All right. You're welcome.
LIEUTENANT MILLER: Bye-bye.
CHRISTA: Bye-bye.
(End of recording.)
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EXHIBIT

"34"

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:27 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:27:15 1/12/2010

Collateral Contact-Social Worker-Yvette Case manager inquired about Medical Records for the minor child Owen C[redacted] Case manager was informed she would need a release of information from the parents and they would not be able to give medical records to her tonight-they stop giving medical records at a certain thing-Case manager would need to get in contact with the hospital in the morning regarding receiving medical records.

Actions:

Face to Face with child/client

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)
0001545390 - Lythgoe, Kayla - 06/12/1990 (E)

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:31 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:31:12 1/12/2010

Safety plan- Owen has acute bleed in the head, actively seizing, multiple bruises chest, arm, thighs, and legs, actively seizing not a good sign-2nd injury much more serious this time. Kayla and Michael will have No unsupervised contact with Owen C[redacted] Owen C[redacted] will not go home with Kayla and Michael. Levine's Children's Hospital will contact York County Department of Social Services when minor child to be released/discharged. Both parents will comply with safety plan-failure will result in court intervention. Case manager Hill will follow up with ALL parties and request records, etc. Parents never arrived back at the hospital-Case manager spoke with Charlotte Williams regarding the safety plan and hospital staff-A copy of the safety plan was placed in Owen's file.

Actions:

Telephone Contact

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)
0001545398 - C[redacted] Owen - 09/09/2009 (E)

EXHIBIT

"35"

HRC690-R01 South Carolina Department of Social Services 5/12/2010 4:47 PM

Case Dictation

Case ID - 0001113743

Actions:

Face to Face with Adult (To Review Treatment Plan)

Face to Face with child/client

Recipients:

0001545390 - Lythgoe, Kayla - 06/12/1990 (E)

0001545398 - C[redacted], Owen - 09/09/2009 (E)

Action Date: 1/29/2010 **Action Time:** 6:30 PM **Time Spent:** 2.00

Input Date: 2/4/2010 **Input Time:** 9:59 AM **Worker:** Golden, Joacquinia

Service ID: 0001388329

Program Service Type: Child Protective Services Assessment

Authorization:

Support Service ID:

Dictation:

AM 9:59:03 2/4/2010

GW Golden made face to face contact with Kayla Lythgoe and her child owen C[redacted]at levine children hospital room# 8 at 1000 blythe blvd charlotte, nc. 704-381-8840 or 704-3812000. CW Golden discuss and explained the safety plan that ycdss had put into place for the safety of the child owen carduff.The safety plan states. Kayla Lythgoe will ensure that all immediate family including but not limited to the following: herself, grandparents and step grandparents, uncles, aunts and cousins are to have supervised contact with owen carduff. This safety plan is effective 1/29/10. Kayla lythgoe is responsible for ensuring compliance with safety plan. DSS will monitor safety plan through follow-up with levine children's hospital. Kayla Lythgoe stated that she understood the safety plan she sign and dated the safety plan. GW Golden gave kayla Lythgoe a copy also GW Golden left copy a copy of the safety plan with Levine children's Hospital staff. CW Golden also observed inside the room was a nursing assistance (sitter) whom stated her responsiblilty was to sit inside the room with the child and mother at all times she was awaiting for someone to relieve her. Kayla Lythgoe mother was also inside the room.CW Golden submitted the YCDSS copy of the safety plan to supervisor krista Hinnant.

PM 8:58:45 2/17/2010

Note: Only Action Code Face to Face with Child/Client should be selected.

Actions:

Initial Face to Face With Child/Client

Recipients:

0001545390 - Lythgoe, Kayla - 06/12/1990 (E)

0001545398 - [redacted], Owen - 09/09/2009 (E)

Action Date: 1/29/2010 **Action Time:** 6:30 PM **Time Spent:** 0.50

Input Date: 2/17/2010 **Input Time:** 9:00 PM **Worker:** Golden, Joacquinia

EXHIBIT 35 473

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 9:00:54 2/17/2010

Summary of Protective Action:Kayla Lythgoe will ensure that all immediate family including but not limited to the following: herself, grandparents and step grandparents, uncles, aunts and cousins are to have supervised contact with owen c[redacted] This safety plan is effective 1/29/10. Kayla lythgoe is responsible for ensuring compliance with safety plan. DSS will monitor safety plan through follow-up with levine children's hospital. Kayla Lythgoe stated that she understood the safety plan she sign and dated the safety plan.

Actions:

Collateral Contact

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)
0001545390 - Lythgoe, Kayla - 06/12/1990 (E)
0001545391 - Williams, Charlotte - 03/01/1969 (E)
0001545398 - C[redacted]Owen - 09/09/2009 (E)

Action Date: 1/29/2010 **Action Time:** 3:35 PM **Time Spent:** 0.25
Input Date: 1/29/2010 **Input Time:** 4:26 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 4:26:31 1/29/2010

Supervisor spoke again with SW Linda Brown at Levine's. Linda stated that they can keep a sitter in the room for the time-being, but that are not sure that they will be able to keep a sitter until February 12th, when Owen is discharged. Supervisor read safety plan to SW Linda Brown that states that "All immediate and extended family including but not limited to the following: parents, grandparents and stepgrandparents, uncles, aunts and cousins are to have supervised contact with Owen C[redacted] Levines Children's Hospital and/or their designee is reponsible for ensuring compliance with this safety plan." Supervisor faxed a copy to SW Linda and Linda confirmed receipt of the safety plan. Supervisor asked Linda if it is possible for her to have the family sign the safety plan and she stated that she would not feel comfortable doing that. Supervisor asked Linda if someone from the hospital would sign the safety plan since they would be indentified as the protector and would be reponsible for ensuring compliance with the safety plan. Linda stated that she was not sure and that she would consult with the nurse in charge and get back with Supervisor.

Actions:

Staffing With Supervisor

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)

EXHIBIT

"36"

C[redacted] Owen [redacted] 000-545-02-19

DATE OF SERVICE: 02/17/2010.

ATTENDING PHYSICIAN: Dr. Colleen Wunderlich.

SUBJECTIVE: Owen was seen in the play gym this morning working with his physical therapist. His mother is present on the floor today but is currently in her room awaiting a phone call. She continued to stay with Owen last night and continues to do very well with him. Owen's discharge is currently on hold secondary to DSS prohibiting him from going home with his mother with his grandmother present. His mother is currently working on clarifying what she needs to do to take Owen home with DSS and also working on finding alternative housing so she does not have to stay with her mother. Owen continues to be pleasant, interactive, and his therapist states that he is smiling more readily.

OBJECTIVE:

Vital signs: Temperature 98.3, heart rate 142, respiratory rate 32, blood pressure 142/76. In general, Owen is awake, alert, smiling, tracking in no acute distress. Lungs: Clear to auscultation bilaterally without adventitious sounds. Cardiovascular: Heart with regulat rate and rhythm, no murmurs, rubs or gallops. Abdomen: Soft, nondistended, nontender, normoactive bowel sounds. PEG tube in place. Extremities: No clubbing, cyanosis or edema. He continues to exhibit volitional movement of all extremities.

LABORATORY: No new labs.

ASSESSMENT AND PLAN: Owen is a delightful 4-1/2-month-old infant boy with acute on chronic subdural hematoma status post nonaccidental trauma x2 with multiple functional impairments and cortical visual impairment as well as state dysregulation, seizure disorder and right-sided hemiparesis.

PLAN:
1. Continue comprehensive inpatient rehabilitation program with three hours of interdisciplinary care per day with physical, occupational and speech therapies. This level of care cannot be provided at a lower level. Continue 24/7 rehabilitation nursing for medication administration, family teaching. Owen also requires support of a specialty trained pediatric rehabilitation physician.
2. Owen's mother did very well with her TLA stay yesterday with no issues. Discharge plan is currently on hold as above and will continue to follow with continued communication with DSS.
3. State dysregulation secondary to severe traumatic brain injury. Continue Klonopin 0.625 mg q.a.m. and noon with 0.5 mg q.h.s. He continues to be awake, comfortable and not sedated on this regimen. He continues to have improvement in his state regulation and is exhibiting volitional movement of all four extremities.
4. Seizure disorder. Owen will continue Keppra for at least two months with plans of repeat EEG on an outpatient basis. He will follow up with Dr. Parrott on an outpatient basis and we appreciate Dr. Parrott's continued assistance.
5. Nutrition. Owen continues to tolerate his tube feeds via the PEG tube. We appreciate nutrition's assistance. In addition, speech therapy would like to repeat a modified barium swallow tomorrow as they feel that he may have progressed since his last MBS.
6. Sleep/wake cycle. Continue Benadryl 2.5 mg q.h.s. p.r.n. as well as Klonopin q.h.s.
7. Social services. DSS continues to be highly involved as above. Visitation plan continues to involve supervised visits only for Owen's maternal grandparents.
8. Outpatient follow up with neurophthalmology as planned.

EXHIBIT

"37"

LEVINE CHILDREN'S SPECIALTY CENTER
HISTORY & PHYSICAL

Carduff, Owen Michael **000-545-02-19**

DATE OF ADMISSION TO CAROLINAS REHABILITATION AT LEVINE CHILDREN'S HOSPITAL: 01/25/2010.

DATE OF ADMISSION TO LEVINE CHILDREN'S HOSPITAL: 01/11/2010 through 01/20/2010.

DATE OF ADMISSION TO PATRICK HOSPICE HOUSE: 01/20/2010 through 01/25/2010.

PRIMARY CARE PHYSICIAN: Dr. Paxtor at Sunshine Pediatrics in Rock Hill.

PRIOR NEUROLOGIST: Dr. Parrott.

HISTORY OF PRESENT ILLNESS: Owen is an adorable 4-1/2 month old male baby who has had a rather complicated medical history with nonaccidental trauma and acute on chronic left frontal subdural hematoma. His first hospitalization to LCH was 12/09/2009 for an acute life-threatening event with a CT scan at that time showing a faux subdural hematoma, as well as right convexity hematoma. Nonaccidental trauma survey done at that time was negative. DSS was involved early and advised parenting classes and a home evaluation upon discharge.

He returned to LCH on 01/11/2010 as an emergent transfer from Piedmont Medical Center with new subdural hematoma and status epilepticus. A new left subdural hematoma was found at that time as were bilateral retinal hemorrhages.

During this second hospitalization he continued to have seizures requiring Ativan, phenobarbital and fosphenytoin, as well as an EVD for elevated ICP, mannitol, hypertonic saline and Thiopental. Subsequent imaging showed left frontal subdural hygroma with abnormal signal in the basal ganglia bilaterally and splenium of the corpus callosum consistent with sequellae of anoxic brain injury, as well as abnormal subcortical white matter throughout the cerebral hemispheres, also consistent with anoxic brain injury.

Neuroradiology and ethics were consulted to help with long-term prognosis and decision making regarding withdrawal of care. It was decided that his long-term prognosis was very poor and support was withdrawn on 01/18/2010 with plans to transition to acute hospice care. Following extubation and discontinuation of sedation Owen was showing some spontaneous eye opening, active gag and cough, spontaneous breathing, withdrawal to pain and very little spontaneous movement. He was continued on IV phenobarbital for seizure prophylaxis, as well as p.r.n. morphine for perceived pain and comfort.

He was transferred to Patrick Hospice House on the 20th. Physicians there report that he was vacant and lethargic upon arrival, but quickly began showing improvement. He began rooting and started taking small p.o. feeds and advancing to formula via bottle. He has been showing some feeding behaviors and becoming more responsive. It still has not seemed that he is seeing or hearing. Given the significant improvements over the last several days, and in concordance with the family's wishes, Owen was reevaluated by physical medicine rehabilitation and is being transferred for comprehensive inpatient rehabilitation for his traumatic brain injury and associated neurological deficits.

Today Owen is accompanied by his maternal grandparents who must legally supervise his mother at all times, as well as his mother who has custody and may sign all consents (no other visitors are allowed). They report that he is doing much better than they anticipated, however, has been very fussy. When he is awake he seems to cry almost constantly with a very high-pitched cry. This has been alleviated by p.r.n. morphine intermittently.

Additionally, he has not been sleeping very well at all. They have not noticed any response to visual or auditory stimuli. They report that he is starting to use his left side more and more. They report that he is having several wet diapers a day and has had some regular bowel movements. They report that he has shown times of aggressive sucking on a pacifier and has been taking small amounts of formula and Pedialyte when offered at hospice.

EXHIBIT

"38"

1/4/10	**Staffing with Supervisor**	**Krista**

Current Situation: Hospital cannot determine if hematomas are Accidental or non-accidental. Concerns for lack of supervision. Charlotte babysits Owen, Baby is doing well. Crib and all baby s Supplies in home. Recs: Get all medical records; follow up with Law Enforcement. What is their status? Assess Grandmother's home-get Incident reports

1/11/10	**Collateral Contact**	**Dirvondra**

Telephone contact received telephone call stating that Owen Carduff was still actively seizing and Michael Carduff was Found guilty-He admitted to shaking the baby

1/11/10	**Face to Face with child/client**	**Dirvondra**

Safety Plan-Owen has acute bleed in the head; actively Seizing, multiple bruises chest, ar, thighs, and legs, actively Seizing not a good sign-2nd injury much more serious this time. Kayla and Michael will have no unsupervised contact with Owen C[redacted] Owen C[redacted] will not go home with Kayla and Michael. Levine Children's Hospital will contact York County DSS when minor child to be released/discharged. Both parents Will comply with safety plan-failure will result in court Intervention. CM Hill will follow up ALL parties and request Records, etc. Parents never arrived back at the hospital-CM Spoke with Charlotte Williams regarding the safety plan and Hospital staff-A copy of Safety Plan was placed in Owen's file.

1/11/10	**Collateral Contact**	**Dirvondra**

SW-Yvette: Case manager inquired about Medical Records for The minor child Owen C[redacted]-CM informed she would need a Release of Information form the parents and they would not be able To give medical records to her tonight-they stop giving medical Records at a certain time-CM would need to get in contact with the Hospital in the morning regarding receiving medical records.

Information highlighted in Blue are documents, forms and etc. in the case record.

EXHIBIT 38

EXHIBIT

"39"

Page 1

STATE OF SOUTH CAROLINA IN THE COURT OF COMMON PLEAS
COUNTY OF YORK SIXTEENTH JUDICIAL CIRCUIT
Civil Action No: 11-CP-46-04508

ELIZABETH HOPE RAINEY, as the APPOINTED GUARDIAN ad LITEM to OWEN C[redacted] a minor,
Plaintiff,
vs.
CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS MEDICAL CENTER, SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES, BRUCE BRYANT as the CONSTITUTIONAL OFFICER OF YORK COUNTY,
Defendants.

VIDEOTAPED DEPOSITION OF LAURA NEWMARK, MSW

T R A N S C R I P T of the deposition in the above-entitled matter by and before KAREN ANN KOCSIS, a Certified Court Reporter and Notary Public of the State of South Carolina, held at the CAROLINAS MEDICAL CENTER, 1000 Blythe Boulevard, Dining Room #4, Charlotte, North Carolina on Thursday, September 27, 2012 commencing at 10:23 a.m.

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A P P E A R A N C E S: (Cont'd)

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ALSO PRESENT: Videographer, Brooks Oswald

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I N D E X

E X H I B I T S

PLAINTIFF'S EXHIBIT 39

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A Sure.
Q Okay. And after being admitted to -- I'm going to call it L -- LCH.
A That's fine, yes.
Q Levine Children's Hospital. If I use the term "LCH" or "Levine Children's Hospital" or "Levine," I'm talking all about the same entity.
A Right.
Q Okay. So after being admitted to LCH, the child was eventually discharged back to his parents; right?
A Yes.
Q And you're aware that approximately 30 days after that, the child came back to Levine Children's Hospital and was catastrophically brain injured?
A Yes.
Q And if he had never been put back with his parents, back to the abuser, the child -- it would have never happened, would it?
MS. BROOKS HOLMES: Objection.
MR. FRAWLEY: Object to form.
THE WITNESS: I can't answer that.
BY MR. HOOD:
Q Why can't you answer it?

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A Because I don't know what would have happened.
Q Okay. Let's -- let's -- let's break it down a little bit for you.
He doesn't go back to his parents on December the 8th, he goes into foster care; right?
MR. TODD: Objection.
BY MR. HOOD:
Q Or with another relative?
MR. TODD: Objection.
MR. FRAWLEY: Same objection.
MS. BROOKS HOLMES: Same objection.
BY MR. HOOD:
Q You can answer.
A I don't have any say as to where he goes upon discharge, as a hospital employee.
Q You work hand-in-hand with a state agency, you-all were retained to determine what happens with a child where there is suspected child abuse involved.
A I --
MR. TODD: Objection.
BY MR. HOOD:
Q You can answer.
A I am a liaison between the medical team

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and DSS.
Q Okay. As a liaison, you are the person that helps get whatever the medical discharge is going to be; right?
MR. TODD: Objection.
THE WITNESS: No.
BY MR. HOOD:
Q Okay. As the liaison, you work as a person between the state agency and the medical doctors?
A Yes.
Q And then you help those two people come together to determine what's in the best interest of the child?
MR. TODD: Objection.
THE WITNESS: No. I share information on the clinical status and what's going on with the patient with DSS, who has the ultimate discharge plan put in place.
BY MR. HOOD:
Q Okay. But I thought that you, according to your own algorithm, that you-all had to do it together?
A I give them information. I don't control the final decision.

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Q Who controls the final decision?
A DSS.
Q Okay. Let me look at your algorithm.
(Child Abuse and Neglect Algorithm marked as Plf's Exh 2 for identification.)
THE WITNESS: Could I get to look at it?
BY MR. HOOD:
Q You're now looking at Plaintiff's Exhibit 1, which are some -- looks like typewritten or some electronic-type of documentation about this baby and then -- that's Exhibit 1, and then Exhibit 2 is a Child Abuse and Neglect Algorithm from Levine Children's Hospital; right?
A Are you asking me? Yes.
Q Yes.
A Yes.
Q Okay. Now, I'm going to go through 2, and then we'll go to 1; okay?
A Okay.
Q Number 2, it says, "Medical team identifies child in whom abuse or neglect is suspected."
Do you see that?
A Yes.
Q And in this case they identified a child

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Q I'm inviting you to tell them who is more vulnerable than a baby under the age of six months? Tell us.

MR. TODD: Objection. This is all argument, this is not --

MR. HOOD: I can ask her any question I want to, brother.

MR. TODD: No, you can't, but you can ask that one.

MR. HOOD: Okay.

MR. TODD: But it's argument and it's really not appropriate.

MR. HOOD: Okay. Who is the most --

BY MR. HOOD:

Q Okay. Explain to me, what the question, who is the most vulnerable in society, tell me how that's argument?

MR. TODD: Look, you're misinterpreting the question. She said --

MR. HOOD: No, no, that's what you said.

MR. TODD: You said that a baby under six months is vulnerable.

MR. HOOD: No, she didn't. I said, "Who is the most vulnerable."

MR. TODD: Anyway, you can go ahead,

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answer if you want to waste our time.

MR. HOOD: Please answer.

THE WITNESS: I don't disagree that a baby under six months is vulnerable. I'm just not saying that they are perhaps the most vulnerable portion of our entire society.

BY MR. HOOD:

Q Okay. And my question is, if they are not the most vulnerable, tell this jury who is the most vulnerable other than a baby under the age of six months?

A I don't think, in my experience as a social worker, that I have the ability to say who's most vulnerable in our society. I'm not disagreeing that a baby under six months is vulnerable.

Q Okay. And is a baby under six months, which Owen Carduff was --

A Yes.

Q -- if you can't rule out that he was a victim of child abuse --

A Right.

Q -- how is he discharged back to his parents?

MR. FRAWLEY: Objection to form.

THE WITNESS: I -- I can't answer that,

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because I didn't make that decision. The workup couldn't say definitively that he was the victim of abuse.

BY MR. HOOD:

Q Have you ever heard of the term "err on the side of caution?"

A Yes.

Q Okay. And when you have a child who may or may not be a victim of child abuse --

A Mm-hmm.

Q -- what is the safest way to ensure they are safe?

MR. TODD: Objection.

MR. FRAWLEY: Objection to form.

THE WITNESS: The safest way to ensure that --

BY MR. HOOD:

Q That the baby is not going to be abused again.

A Part of the safety net and working on discharge, as far as the hospital social work piece, is to get DSS involved, because they can be involved in the home community, where we can't.

Q Okay. And then let's go back to this -- this algorithm that we looked at earlier, and I

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believe that was Exhibit 2, at the bottom.

A Yes.

Q At the bottom it says, "when medically cleared." Do you see that?

A I do.

Q Okay. And what is "medical clearance?"

A When the child would be medically stable enough to leave the hospital.

Q Okay. Does that mean that the child -- even if they are medically stable, does it mean that it's in the best interests of the child to go back into the care of their parents?

A The -- I don't -- I don't really understand what you're asking.

Q Sure. When you say they are medically cleared, that means the child is stable.

A Medically stable.

Q For whatever the reason -- excuse me, I apologize.

A Yes.

Q So they're stable from the standpoint of the reason they actually came into the hospital in the first place?

A Right.

Q Okay. And when they are medically stable

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for the reason they came into the hospital, "do not discharge until disposition has been determined by medical social worker and DSS."

That's what that says; right?

A I see that.

Q You have a joint responsibility, don't you?

MR. TODD: Objection.

THE WITNESS: My responsibility as the medical social worker is to communicate information to DSS from the team and back to the medical team from DSS.

BY MR. HOOD:

Q Okay. And where is that on the algorithm?

A I don't know.

Q Okay. Let's look at the policy, then. Let's look at your Child Maltreatment Guidelines, maybe we can find something there.

MR. HOOD: Can I have this marked as 5?

THE REPORTER: Here you go.

THE WITNESS: Thank you.

(Child Maltreatment Clinical Practice Guidelines received and marked as Plf's Exh 5 for identification.)

BY MR. HOOD:

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Q Have you ever seen this before?

A Probably. I can't say exactly when and where I would have.

Q Okay. At the top it says, "Child Maltreatment Clinical Practice Guidelines, Clinical Practice Guidelines, CHS inpatient units in emergency department, evaluation and management of the suspected child abuse or neglect."

Do you see that?

A Yes.

Q And do you see under the big Roman numeral I, it says, "Child physical abuse"?

A Yes.

Q And then under A it says "Identification." Do you see that?

A Yes.

Q And then it says, "Injuries, bruises, burns, fractures; This list is not inclusive (that should be considered suspicious for physical abuse:)" Do you see that?

A Yes.

Q "Number 1, age zero to six months: Any injury." You see that; right?

A Yes.

Q This child was about three and a half

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months old at the time he came in; right?

A If you say so.

Q I'll represent --

A It says two months on my note.

Q He was born in September.

A Okay.

Q I think it's like the middle of September, and then he came in the 1st of December. So he was between two or three months, something like that.

A Okay.

Q That would be between zero and six months though; right?

A Yes.

Q And then B, "Essential aspects caretaker history." Do you see that?

A Yes.

Q It says, "Does the parent, guardian or child give a logical explanation that is consistent with the age, pattern and severity of the injury."

Do you see that?

A Yes.

Q "This should be assessed by clinician familiar with normal pediatric development."

Do you see that?

A Yes.

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Q Now, as part of the social worker team at Levine Children's Hospital, did you have interaction with the parents in this particular case?

A Yes.

Q Okay. And did you attempt to assess or determine what was the cause of this subdural hematoma?

A I would have taken a history from the parents on had there been any recent trauma.

Q Okay. And in this case, the parents said they don't know how it occurred; right?

A They didn't have any history of a traumatic event.

Q So there would have been no explanation, a logical explanation, that was considered -- consistent with the age, pattern or severity of the injury, did they?

A They didn't have a history of trauma that would have explained an injury.

Q Okay. And according to your note, this -- this -- this one that we had looked at earlier, this Exhibit -- Exhibit 1.

Before you would have done your note on 12/7, you would have looked at the other person's note on 12/6; right?

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first about Owen C[redacted] on 12/4/09.
A Okay.
Q It has "D-C home," that's discharge home; right?
A Yes.
Q Okay. So my question is, there appears to be some type of -- someone who is tracking what's happening with those at-risk children in regard to their -- what's happening when they leave; right?
A It looks like Lynn has kept a database, yes.
Q Okay. And that some of these at-risk children are discharged home; right?
A Some of the kids that have had a workup or had DSS involvement, yes, they're discharged home.
Q And then some are discharged to a relative.
A Yes.
Q And then some may be discharged to a foster care situation.
A Yes.
Q And all of that is dependent upon the decisions by the hospital and the county social work state agency?
MR. TODD: Objection.

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MR. FRAWLEY: Same objection.
THE WITNESS: I -- no.
BY MR. HOOD:
Q Okay. And whose decision is it where the child goes?
A The county DSS agency.
THE REPORTER: I'm sorry?
THE WITNESS: The county DSS agency.
BY MR. HOOD:
Q Okay. And if -- so is it your -- and I'm not saying it is -- is it your testimony, that the hospital has no responsibility as far as the child being able to leave if they can't rule in or rule out non-accidental trauma?
MR. TODD: Objection.
THE WITNESS: That the hospital -- say that again.
BY MR. HOOD:
Q Sure, sure. And I apologize, it may have been inartful.
Do you have an opinion --
A Okay.
Q -- about whether the hospital has a responsibility to Owen C[redacted] to ensure his discharge back to a safe environment?

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MR. TODD: Objection.
MR. FRAWLEY: Objection to form.
THE WITNESS: In my opinion?
BY MR. HOOD:
Q Yes.
A I think that the medical team has a responsibility to do a workup on a child that comes in with an unexplained injury and part of that is calling DSS, working with them, making sure they have all the right information, doing everything we can to do a complete workup, as a way to help protect him. I --
Q Okay, okay. And so the medical workup in conjunction with the work of the state child welfare agency --
A Um-hmm.
Q -- would then determine his most likely placement?
A I would hope that a medical workup, being communicated well with the local DSS agency, would help in assuring a safe discharge.
Q Okay, okay, okay. And you would agree that a safe discharge would be appropriate for a vulnerable child?
MR. TODD: Objection.

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You go ahead and answer.
THE WITNESS: You know, I think certainly we hope that whatever happens would be medically safe and stable for the child.

BY MR. HOOD:
Q Okay. Now, you've been working in a hospital environment for -- for how long have you been at --
A I started in January of '03.
Q Okay. So at the time that this occurred, about six years; right?
A Part time.
Q Part time. And before that, had you ever worked for a county agency?
A Not a DSS, but a county mental health, yes, in the school system, yes.
Q So you had worked with children before you actually came to Levine?
A Yes.
Q Okay. And you had received training in regard to being able to spot child abuse; right?
A Yeah -- yes.
Q Okay. And you are aware that an unexplained subdural hematoma is not normal for a

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Q Back into the same environment; right?
A I don't know who's present before, during, after, but he was discharged home, yes.
Q Okay. With his mother and father?
A Yes.
Q The same people that had no explanation for the bruise or the subdural hematoma; right?
A Mm-hmm.
MR. TODD: Okay. You need to answer -- We've I think everybody is getting your answer, but the court reporter likes a verbal response.
THE WITNESS: Sorry, I'm sorry.
MR. TODD: And the videographer likes a -- to be able to pick it up on the microphone.
THE WITNESS: Okay.
MR. TODD: I think we all understood your answer.
MR. HOOD: And what we may do, if you-all want to, I don't know what we're going to do from a housekeeping perspective, but if you want to take a break like every hour or so, and I don't care. I'm perfectly fine to keep going.
MR. FRAWLEY: How much time we've been going?

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THE VIDEOGRAPHER: 85 minutes.
MR. HOOD: We've been going 85?
THE VIDEOGRAPHER: No, that's how long the tapes are.
MR. HOOD: Okay. How long --
MR. TODD: You need a break?
THE WITNESS: Yeah, a break would be nice.
(Brief recess.)

EXAMINATION

BY MR. HOOD:
Q I want to go back to what your role is, if that's okay.
A Okay, sure.
Q And I know you've got a master's and -- and I believe -- and correct me if I'm wrong, please correct me if I'm wrong.
A Mm-hmm.
Q It's my understanding that you're a liaison between the medical team providing care for Owen in the hospital and the DSS workers from South Carolina.
A Yes.
Q Okay. Now, is it your testimony -- and I'm not saying you've testified this way, I'm just trying to find out.

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A Right, sure.
Q Is it your testimony that you have no decision-making ability in that regard?
MR. TODD: Objection.
THE WITNESS: Decision-making ability in what regard?
BY MR. HOOD:
Q If anything, all you are is just a messenger back and forth between the two of them.
A No, I can give my opinion to the doctors or -- and say that if there's anything in particular.
Q Okay. Well, in this particular case, what insight did you give to the doctors?
A I don't recall, off the top of my head, the conversation, I mean...
Q Let's look at this. The only thing that I can see that really has your stuff on there is this -- where you -- you had your notes.
A This one?
Q Yes. And I think that was Exhibit 1.
A Um-hmm.
Q And that actually has Laura Newmark at the bottom of it; right?
A Right. Yes, that's my signature.

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Q Right.
A '93 or '94?
Q Yes. '93.
A Okay.
Q And we'll get to the other.
But it says, "DSS to staff determine likely to allow discharge home with parents, child maltreatment coordinator has seen child as well, nursing following updated RN Tracy will follow."
A That's "neurosurg," not "nursing."
Q Okay, I'm sorry, neurosurgery.
And neurosurgery, in this case that was Dr. Scott McClanahan then; right?
A I think I saw his name, I don't remember.
Q Okay. Now, would you have spoken to neurosurgery?
A Not typically, no.
Q Is -- is -- and this is where I'm trying to get an understanding. What is the CHIPS team at LCH?
A That is the children's hospital inpatient services.
Q Okay.
A So it's the staff physicians, the staff pediatricians and the residents that are rotating

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accidental or non-accidental"?
A I don't recall specifics of the conversation.
Q What about the generalities of the conversation?
A I don't have any clear recollection.
Q In going through the medical records and looking at this and thinking back, do you have a general idea about what you would have determined whether it was accidental or non-accidental?
A I'm sorry, I didn't follow you.
Q Sure. In this particular case, I believe you testified earlier that you would have had some conversation with a doctor; right?
A Yes.
Q Krista Hinnant says -- she documents that she has spoken to you.
A Okay.
Q Now, I'm not saying you did or you didn't, but she's documented that?
A Sure.
Q And then I think you've documented that you did speak to Krista Hinnant; right?
A Right, sure.
Q And then in hers it says, "The hospital

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cannot determine whether injuries are accidental or non-accidental."
A Okay.
Q It appears that that information is coming from you; right?
A Right.
Q My question is, do you -- how did you get that information that they couldn't determine one way or the other?
A I would have reviewed his progress notes, the notes from the doctors --
Q Okay.
A -- specialists, subspecialists, and talked with the physician.
Q And when you talked to the physician, you're talking about somebody that is a member of the CHIPS team?
A Yes.
Q Okay. After that it says, "Owen's eye exam and skeletal survey were negative."
Do you see that?
A Yes, I do.
Q And now, you probably don't know this, but I'm going to ask, do you know if he was seen by a pediatric ophthalmologist?

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A I don't know. I know there are pediatric ophthalmologists on staff.
Q Okay.
A I don't know specifically who saw him.
Q Do you know if they did a direct eye exam or indirect eye exam?
A I wouldn't know.
Q Do you know if they used fluoroscopy or not?
A I would not know.
Q Okay. Says, "Going to repeat CT today, because Owen's head appears to be swollen. Family has no clear history of trauma; however, hospital cannot rule out trauma."
Do you see that?
A I do.
Q Now, if you can't rule out trauma, how can a child be medically discharged back to his parents?
MR. TODD: Objection.
THE WITNESS: I -- he was medically ready for discharge.
BY MR. HOOD:
Q "Medically ready" does not mean safe for the juvenile to the return to his parent, guardian, custodian or caretaker, though, does it?

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MR. TODD: Objection.
THE WITNESS: They're two different things, yes.
BY MR. HOOD:
Q Okay. And I understand "medically stable," that's like if he came in with a subdural hematoma, they could have some kind of sequelae or something -- a physical manifestation or some kind of something that caused a medical condition and they've got to treat that; right?
A Right.
Q And -- and he then becomes stable, his vitals were okay, subdural -- the repeat CT shows the subdural is being absorbed, and -- and he is, by all intents and purposes, okay to discharge from a medical standpoint.
A Yes.
Q Now, but as you said, it's different than safe to discharge to return to parent, guardian, custodian or caretaker, though; right?
A I don't think we can predict the future on what is or isn't going to happen in working with DSS.
Q And I agree, you don't have a crystal ball.

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A Yes.
Q That would be important to someone from DSS?
A Yes.
Q And if the safety plan was to follow the medical advice of the hospital and doctor recommendations not to remove child from hospital until medical discharge, if that was the safety plan, that they are not going to remove them from the hospital until the doctor says it's okay, is that okay with you?
MR. TODD: Objection.
MR. FRAWLEY: Objection to the form.
THE WITNESS: So I --
BY MR. HOOD:
Q Let me ask you a different question.
A Yeah, I don't understand.
Q Terrible question.
You see safety plan where it says "Follow medical advice of hospital and doctor recommendations" --
A Right.
Q -- "not to remove child from hospital until medical discharge." You see that; right?
A Yes. I read those as two different

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things.
Q Okay. How do you read those?
A I read that as "Follow medical advice of the hospital and doctor recommendations," which is pretty typical, whatever follow-up, medicines, appointments that the family has to comply with treatment herein before they leave.
Q Sure.
A And then I read "not to remove child from hospital until medical discharge" as what the parents -- the parents can't take the child out of the hospital until the doctor has said that the child is medically stable for discharge.
Q Now, is it -- and I see -- I -- I understand what you're saying, sure.
A Okay.
Q And I'm not -- I won't put words in your mouth. I want to know what you think.
A Right.
Q Now, we talked a little bit about that -- that there are -- a child can be medically stable, but it still may not be safe to discharge a child home if there are positive findings of child abuse?
MR. TODD: Objection.
THE WITNESS: I -- the child can be

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medically stable and ready for discharge.
BY MR. HOOD:
Q Sure.
A I think we would continue to work with community resources and make sure that there was going to be appropriate follow-up, if we were concerned that the follow-up wasn't going to happen.
Q Okay. And appropriate follow-up could be discharge home, discharge to relative, or discharge to foster care.
A Yes, disposition and discharge would be at the DSS discretion.
Q Okay. So it's your testimony under oath that the disposition or the discharge of the child from the hospital back into the parents' care is completely dependent upon DSS?
A In my experience, yes. DSS tells us, when there is an open investigation, where the child is going to be discharged to.
Q Okay. And it is your testimony under oath that as far as a hospital's role, it is simply to treat the child and make sure that they are medically stable to be able to be discharged.
A I -- we treat the child, if we have concerning findings, we have a duty to call DSS or

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other agencies, if we need to, and work with them and they tell us discharge disposition.
Q Okay. And you said that the disposition is the social -- is the state agency's responsibility?
A It is what -- yeah, it's DSS.
Q Okay.
A If they're going to take custody or not or where the child is going to be discharged to.
Q Okay. And if we look back at Exhibit 10.
A Which one is 10?
Q This is that one -- well, 10 is the policy on juveniles suspected of being abused or neglected.
A Okay, okay. Right.
Q Could you read number 9 for us?
A "When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS and a safety plan has been placed on the chart in writing, if applicable."
Q Okay. Where it does it say it is determined by the social worker -- by DSS only?
A Disposition has been determined by medical social worker and DSS -- the way that I could read that, back to me being a liaison, that I'm making sure that the team knows that DSS is involved in

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what they recommended.
Q Okay. So even though this says what it says, it's your testimony that it's DSS's responsibility and not the hospital's, the disposition?
A To determine place of discharge, yeah.
Q Okay, okay, okay.
If we go to B.
A Yeah.
MR. TODD: Are we still on 10?
MR. HOOD: Yes.
BY MR. HOOD:
Q It says, "When a physician determines that a juvenile should remain in the hospital for medical reason."
Do you see that?
A I do.
Q And that's about stability; right?
A Right.
Q "Or that it is unsafe for the juvenile to return to his or her parent, guardian or caretaker."
Do you see that?
A When a physician determines that it is unsafe, yes.
Q So they have two things they have to

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determine: One, the child is medically stable; and two, that it's safe to discharge him back to the parent or caretaker; right?
A The -- the physician has to -- so the physician has to determine that the child is medically stable.
Q Right.
A Yes. And then know what the discharge plan is for a child that is involved with DSS. Is that what you're asking?
Q I'm just reading the policy, "Or that it is unsafe for the juvenile to return to his or her parent, guardian or caretaker."
A Well -- okay. It seems like an "or." When a physician determines that they should remain in a hospital for medical reasons or that it is unsafe.
Q Right, one of the two.
A So they have to determine one of the two if they want to pursue the 12-hour custody.
Q Right. But -- but -- but let's say that in order for them to determine one of the two, they've got to consider both, though; right?
A If -- if they are pursuing the -- excuse me, the 12-hour emergent physical custody. I think

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that's what that paragraph is.
Q And why would they do the pursuit of the 12-hour physical custody?
(Intercom interruption.)
THE WITNESS: All right. Sorry. When -- when would -- I'm sorry, ask me again.

BY MR. HOOD:
Q Sure. And it may be we read the whole thing and it may be --
A Okay.
Q -- you answered the question, and that's my fault.
A Okay, okay.
Q Okay. It says, "When a physician determines that a juvenile should remain in the hospital for medical reasons or that it is unsafe for the juvenile to return to his or her parent, guardian or caretaker, the physician or administrator should first contact the Director of Department of Social Services to determine if DSS will take emergency custody and authorize the hospital to retain physical custody of the juvenile."
A Okay.
Q "In the event DSS is unwilling to take

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custody or cannot be contacted, the local district court has authorized the physician or administrator to retain physical custody of the juvenile whenever the physician determines that the juvenile should remain for medical treatment or, according to his or her medical evaluation, it is unsafe for the juvenile to return to the parent, guardian, custodian or caretaker."
Do you see that?
A I do.
Q Now, that second paragraph says, "If DSS is unwilling to take custody or cannot be contacted."
A Yes.
Q Before it puts that 12-hour administrative order in and talks about that other stuff, about "the juvenile should remain for medical treatment or according to his or her medical evaluation, it's unsafe for a juvenile to return to his parent"; right?
A Yes.
Q Okay. Now, my question to you is, okay, in order for them to determine that, whether a child is medically stab- -- you've agreed they've determined that the child was medically stable?

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discharge of any child would not be back into an abusive situation.
BY MR. HOOD:
Q And a hospital should make sure a baby is diag- -- diagnosed with a cause of a head injury before discharging back to parents?
MR. TODD: Objection.
MS. BROOKS HOLMES: Objection.
THE WITNESS: No, I wouldn't agree with that, because you can't always say.
BY MR. HOOD:
Q If you can't say what was the cause of a head injury, you should err on the side of caution before discharging a three-month-old baby back to parents that had been suspected of child abuse?
MR. TODD: Objection.
MR. FRAWLEY: Objection.
MS. BROOKS HOLMES: Objection.
THE WITNESS: I don't agree that the parents were suspected. A report was made, and in terms of erring on the side of caution, we'd rather make the report to DSS than not and hope that DSS can do a complete follow-up that we can't do here in the hospital.
BY MR. HOOD:

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Q Okay. Doctors in hospitals should err on the side of caution in cases of suspected child abuse?
MR. TODD: Objection.
MR. FRAWLEY: Is that a question?
MR. HOOD: Sure.
MR. FRAWLEY: Objection.
MS. BROOKS HOLMES: What was the question?
BY MR. HOOD:
Q Doctors in hospitals should err on the side of caution in cases of suspected child abuse; correct?
A Yes.
Q And doctors and hospital personnel should follow policies and procedures; right?
A Yes.
Q Okay. There was mention during this stuff that I read about the child maltreatment team, and I think it was a Miss Myers or something.
A Right.
Q Is the child maltreatment -- is it a team or is it just one person that's a coordinator?
A There is a nurse coordinator and a physician consultant that she works with, and then they might talk -- excuse me, they might talk to the

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social worker who is involved or the team.
It's a coordinator role with a physician consult piece to it.
Q Do you know who back in 2009 was the physician coordinator?
A In 2009 specifically? Dr. Morgan was here, Dr. Mackens might have been.
Q Okay.
A Maybe Dr. Rogers. I don't remember specifically.
Q You've heard of a Dr. Courtlandt?
A Yes.
Q You know Dr. Courtlandt?
A Yes.
Q Have you ever heard of -- I can't remember his name -- does a "Sheldon" ring a name?
A No.
Q I don't know what his name is.
A No, it doesn't.
Q It's somewhere in there. We'll figure it out in the next deposition.
MR. TODD: Maybe.
MR. HOOD: Hopefully. It's written somewhere, I just can't read it.
MR. TODD: Yeah, if you can give me the

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page number, not today, but later, I'll tell you who it is.
MR. HOOD: Hold on a second. I might even have it right here.
BY MR. HOOD:
Q Maybe Stephen Renfrow.
A I know Dr. Renfrow.
Q Yeah.
A But I think he would have been a resident then.
Q Okay.
A Is there an "R?
Q It's just in the -- the interrogatories.
A Oh, okay. Sorry.
THE REPORTER: How do you spell his name?
THE WITNESS: R-e-n-f-r-o-w, I think it is.
BY MR. HOOD:
Q Stephen Renfrow, yes.
A "/R"?
Q It has "MD/R."
A That means he was a resident at the time.
Q Okay.
BY MR. HOOD:
Q Okay, okay. And the CHIPS team, I think

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right?
A Right. And I think he was discharged the next day when I wasn't working on a Tuesday.
Q Okay.
-- "notified the South Carolina Department of Social Services of the potential of non-accidental trauma to Owen C[redacted]
You agree with that?
A Potential, yes.
Q And that "The South Carolina Department of Social Services responded, conducted its own investigation in the matter, and determined that Owen Carduff could be discharged back into the custody of his parents."
Do you see that?
A I do.
Q But you said you don't know when they finished their investigation; right?
A I know they started it and they have a certain period of time to finish it.
Q And you don't know if they actually determined that he should be discharged back into the custody of this parents, do you?
A No. They gave us permission to discharge him to his parents.

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Q Because you-all medically discharged him; right?
A He was medically ready for discharge, and then we would need to work with DSS to make sure that they knew that he was medically ready, and then we would look to them for where he would actually be discharged to.
Q Medically ready would be medically stable and safe to discharge back into the home of his parents?
A Medically ready would be stable and then to look to DSS for the disposition.
Q Okay. It says 24, I'm sorry, Page 13. It says, "With the finding of non-accidental trauma in December of 2009, describe whether or not the hospital had a duty or responsibility to discharge the child into the hands of a person or entity who was not suspected of perpetrating abuse or trauma to the -- on the child."
And then response was, "The defendant CMC's duty was to notify the appropriate state agency of the potential of non-accidental trauma, which it did."
You-all did?
A Yes.

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Q "Carolinas Medical Center complied with that duty of notifying the South Carolina DSS of the potential of non-accidental trauma with Owen C[redacted]"
Do you see that?
A Yes.
Q And so, it is -- do you have -- do you have an opinion about whether the hospital had a duty, other than notifying South Carolina DSS of the potential of non-accidental trauma, in regard to the disposition of the discharge?
MR. TODD: Objection.
MR. FRAWLEY: I'll object as well.
THE WITNESS: Did the hospital have a duty to contact DSS?
BY MR. HOOD:
Q No, no, no. Did the hospital have a duty other than contacting DSS in regards to the disposition of the discharge of the child?
A No. I think the hospital fulfilled its duty in making the report to DSS and providing them with up-to-date information.
Q Okay. And it is your testimony that that is the responsibility of the hospital --
A I think --

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Q -- and that was their responsibility?
A I -- yes.
Q And the responsibility of whether it was safe to discharge him back into the home with his parents or not was not the responsibility of Carolinas Medical Center or Levine Children's Hospital or the team?
MR. TODD: Objection.
THE WITNESS: I --
MR. TODD: Go ahead and answer.
THE WITNESS: I think the responsibility was to do an appropriate medical workup with all the specialties and sub-specialties, make the initial report to DSS, and make sure they had all the current, up-to-date information about Owen so that they could direct the hospital on discharge.
BY MR. HOOD:
Q Okay, okay. Have you ever had your deposition taken before?
A A deposition, no.
Q Prior to this deposition, had you had an opportunity to review any of the medical records or policies?
A I had met with Mr. Todd, yes.

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Q God bless you for that, that's tough. Do you know why you recommended parenting classes or why they recommended the parenting classes?
A I think it was primarily because of their young age.
Q Okay. Are you aware of any literature that the very young are at risk for being child abusers?
A I think -- not a specific literature site off the top of my head, no.
Q Sure. But you're aware, that there are -- because of what you do and because of your education and because of your experience, that there are certain risk factors for populations that are more subject to being abusers than not.
A Right.
Q I mean, it can be -- I've read statistics where it said people who were not married were more likely to abuse rather than married parents.
A Right.
Q People under a poverty level of like $15,000 a year.
A Right.
Q Young parents under the age of 21.

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A Right.
Q People who complain about a child being fussy all the time because they don't -- they are almost naive about the care that a child is supposed to receive? Have you seen anything like that?
A I don't know about the last one, people that complain all the time, but I do think I would agree with the other ones.
Q That there are certain risk factors?
A Yes.
Q Okay. And -- and when you worked with DSS and you worked with the medical team as a liaison, you would have had to have taken those risk factors into consideration, right?
A It would be part of the workup, yes.
Q Okay. As a social worker, did you make any clinical assessments of either parent to determine if either were a risk of being or becoming abusers of their child?
A My interaction with them would have been more brief than Katie's was.
Q Okay.
A Just because their story about the admission would have already been told and DSS would have already been involved, so generally we don't

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continue to ask them to share the story over and over again.
Q Was there ever any recommendation by you, a physician, or any other representative of Carolina Healthcare System that DSS should not discharge Owen back to his parents?
A Not that I know of.
Q Okay. And you agree that it's within the scope of the physician's treatment to recommend that a child not be discharged back to his parents?
A I know that the physician can give their opinion.
Q Sure.
MR. HOOD: That's all I have.
MR. FRAWLEY: DSS has no questions.
MS. BROOKS HOLMES: No questions.
MR. TODD: No questions.
(Videographer's closing statement.)
(Off video.)
THE REPORTER: And we do waive; right?
MR. TODD: Do you want to read and sign this? You have a right to read it if she made an error.
MR. HOOD: Her face is like, no.
THE WITNESS: No, I'm done, I'm good.

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(Deposition concluded at 1:47 p.m.)
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EXHIBIT

"40"

STATE OF SOUTH CAROLINA IN THE COURT OF COMMON PLEAS
COUNTY OF YORK SIXTEENTH JUDICIAL CIRCUIT

Civil Action No: 11-CP-46-04508

ELIZABETH HOPE RAINEY, as the APPOINTED GUARDIAN ad LITEM to OWEN C[redacted], a minor,

Plaintiff,

vs.

CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS MEDICAL CENTER, SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES, BRUCE BRYANT as the CONSTITUTIONAL OFFICER OF YORK COUNTY,

Defendants.

VIDEOTAPED DEPOSITION OF CHERYL COURTLANDT, M.D.

T R A N S C R I P T of the deposition in the above-entitled matter by and before KAREN GAGLIARDOTTO KOCSIS, a Certified Court Reporter and Notary Public of the State of South Carolina, held at the CAROLINAS MEDICAL CENTER, 1000 Blythe Boulevard, Dining Room #4, Charlotte, North Carolina on Thursday, September 27, 2012 commencing at 2:27 p.m.

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ALSO PRESENT: Videographer, Brooks Oswald

I N D E X

E X H I B I T S

EXHIBIT 40

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determine it one way or the other.
A Right, right.
Q And in Owen C[redacted]s situation, it's your testimony you couldn't determine one way or the other?
A Right.
Q Okay. Now, before he was discharged, you're aware that there is documentation in the chart that the child had a bump on his head a week or two before this?
A Right.
Q And there is no explanation from anybody because of that bump?
A Right.
Q And you're aware that -- that in this particular situation, there was a CT showing two subdural bleeds, one a falx hematoma of which there was no explanation from the parents?
A Yes.
Q You're aware the parents were both under the age of 20?
A Yes.
Q You're both aware that -- that -- I mean, at least from the documentation, it appears that there were money problems in the home.

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A Not to my knowledge.
Q There is documentation about the child had been crying incessantly or had been for the week before that had been irritable.
A According to the documentation in the intake history and physical by the resident, the original reason why the father took the child for the -- to the first visit was that he was fussy.
Q And you're aware that there are risk factors for -- for people who may commit child abuse?
A Yes, sir, I am aware there are risk factors.
Q And -- and when you have those risk factors that you have in this case with an unexplained bump on his head a week before, an unexplained falx hematoma, an unexplained right convexity hematoma, and there is no explanation from the parents, how do you characterize that?
MR. TODD: Objection.
THE WITNESS: The bump on his head, that was referred to previously, was not present, he had absolutely no skin findings, no bruising whatsoever, the -- from my understanding, the bump on the head was something that was

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reported to the DSS worker and was not reported to us.
The subdural hematoma is a finding that we see that can have many different causes, one of which is accidental trauma; one of which is non-accidental trauma.
There was no story that went along with a cause for this, the cause was unknown.
Q Okay. And -- and you had an opportunity to review -- I mean, just because of you being a pediatrician, you've had the opportunity to review AAP documents and AAP literature and just literature in the medical field about child abuse; right?
A Yes.
Q And if -- if somebody is perpetrating child abuse, they don't necessarily always say, "Oh, yes, I committed abuse on my child," do they?
A That's true.
Q And when you have a situation like that and the parents don't have an explanation for this subdural hematoma, why was the child discharged without ruling it in or ruling it out?
A Well, we attempted to, by doing a retinal exam, which can be corroborating information, we attempted to, by doing a skeletal survey, which can

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be corroborating information, both of which were normal.
They were observed in a room 24 hours by a sitter. The nurse documented family check-ins to look at appropriate behavior, to assess what his interaction was with the family. They were appropriate when approached by us, good eye contact, really involved, they appeared to be loving.
There was no explanation that they gave that could have happened to this. It could have been accidental. He had numerous caretakers, his mother, his father, as well as his grandmother. Many of them -- any of them could have injured him accidentally and just are got giving a story, all of that is a possibility.
Q I have read the literature that said a fall from 4 feet or less usually doesn't result in an intracranial hemorrhage. Have you read that?
A It doesn't usually -- a skull fracture doesn't usually occur.
Q Okay. An intracranial hemorrhage isn't something that you just see that happens spontaneously in most three-month-old children; right?
A In most three-month-old children. There

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Q When you have a child who has these subdural hematomas and has some of the risk -- the parents have some of the risk factors, how do you err on the side of the caution if it's either accidental versus non-accidental?

MR. TODD: Objection.

THE WITNESS: By taking the steps that we did; by asking for a child maltreatment evaluation; for getting the child a maltreatment physician involved; from getting Department of Social Services and law enforcement involved. That's how you err on the side of caution.

BY MR. HOOD:

Q Okay. And so you would have gotten the pediatric ophthalmology consult?

A Yes.

Q And that came back negative?

A Negative.

Q Although you don't know how it was done?

A No.

Q Would you have gotten a pediatric neurosurgery consult --

A Yes.

Q -- with Dr. McClanahan?

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A Yes.

Q And he would have -- it appears that somebody with him would have ordered the CTs and they would have been looking at the CTs and they would be medically treating the effects of the subdural hematoma?

A Or evaluating if they need treatment.

Q Right, evaluating.

But the bottom line is that the CHIPS teams, of which you were the attending physician, would have been the responsible party for determining if the child was appropriate for discharge or not?

A I would be the appropriate person to determine if the child was medically cleared for discharge.

Q Okay. Now, there are two components of medical discharged, aren't there? I mean -- and when I had say that, what I'm asking is, you have to be medically stable; right?

You agree with that?

A Yes.

Q And then in regard to child -- either suspected or potential child abuse or trauma, you also have to determine that it is safe for the child

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to be discharged back into the home?

A That's not my determination.

Q Okay. Let's look at -- I'm going to ask you to look at -- yeah, I think it's in this stuff right here.

A Okay.

Q I think it's -- I think it's Exhibit 9 and Exhibit 8 and Exhibit 7.

Exhibit 8, Exhibit 9 and Exhibit 7.

Exhibit 7 is simply an administrative order for Retention of Custody for Juvenile Suspected of Being Abused Pursuant to North Carolina General Statutes; right, right?

A Yes. I don't know what this form means, but yes, I guess that's the heading of this form.

Q Okay. These are attachments to a Child Abuse and Evaluation Policy at Carolinas Healthcare System.

And Number 8 is the Certification of Necessity for Retention of Custody.

Do you see that form?

A Yes.

Q Okay. And then the next form is Examining Physician's Certification.

A Yes.

Q And under that it says, "The undersigned

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examining physician hereby certifies there is good cause to suspect that the juvenile was abused and should remain in blank, name of facility, for medical treatment or it is unsafe for the juvenile to return to his parent, guardian, custodian or caretaker."

Do you see that?

A Yes.

Q So do -- does the physician at Levine Children's Hospital have the ability to state that it's unsafe for a juvenile to return to his parent, guardian, custodian or caretaker?

A If the circumstances of a specific case do come that you can say without a doubt that child abuse has occurred, you could, then, I guess, feel comfortable signing this form.

Q Okay. I'm going to use the converse; okay? If you can say without a doubt that it did not occur, you could safely discharge him home; right?

A Again with the negatives, what?

Q Okay. If you can safely -- if you can say --

A Yes.

Q -- that unequivocally there was no child

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abuse, it is safe to discharge him?
A Yeah, I guess, yes.
Q It's the converse of what you said?
A Yes, yes.
Q You said "equivocally." If you said there was a child abuse, you could say it may not be safe to send him home?
A Yes.
Q But if you take the exact converse, if you can say unequivocally there was no child abuse, you can safely send him home; right?
A Yes.
Q Now, but Owen C[redacted] fell in between those two things?
A Yes. There was some elements of the workup that stated that there was concern for non-accidental trauma, but other elements of the workup of the evaluation which did not meet the criteria because they were negative and therefore, it could not be determined whether or whether not he had been the victim of child abuse.
Q Okay. And I think one of the things you said was the skeleton survey?
A Skeletal survey.
Q "Skeletal survey."

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A Right.
Q And the skeletal survey would have been where they do radiograph of both arms, both legs, and your core.
A Yes.
Q And your head?
A Yes, "and your head."
Q And they determine whether there's been any previous fractures or evidence of any kind of breaks or something that would indicate any kind of trauma; right?
A Yes.
Q Now, when you have abusive head trauma, would you agree with me that many times you do not see any other signs of symptomology on a skeletal exam?
MR. TODD: Objection.
THE WITNESS: It depends on the specifics of the case.
BY MR. HOOD:
Q It depends on the actual case itself?
A Yes.
Q And when you have someone who has an isolated incident of abusive head trauma, you may not see anything on a skeletal survey; right?

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A You may or may not.
Q Okay. And so in this particular case, because of the abusive head trauma -- excuse me.
In this case, because of the subdural hematomas, the skeletal survey may or may not help?
A May or -- it may or may not help, depending. You may also repeat it in two weeks to see if there were any injuries that were young and were fresh if you didn't see them on the first skeletal survey.
Q And -- and in doing that I know there's a huge, huge controversy over shaken-baby syndrome that is now called abusive head trauma.
A Yes.
Q And I know that -- there is a classic triad. I know there's a -- a -- you know, there are mimics that are written about in the literature. I know that they don't even use that nomenclature anymore --
A Sure.
Q -- in the medical field?
A Right.
Q It's now AHT --
A Right.
Q -- as opposed to SBS?

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A Right.
Q And when you have a situation and you've ruled everything out except for either accidental or non-accidental trauma, how do you ensure a baby is safe if you don't know that it's not non-accidental trauma?
A You put in place a safety plan and you report them to the Department of Social Services and you get law enforcement to involve -- to investigate if they can further get information to see if there is anything that corroborates for there to be accidental or non-accidental trauma.
Q Okay. And so when you get it to a point where you've ruled in or out everything except for accidental versus non-accidental trauma, then you work with DSS and law enforcement to determine whether it's one of the two; right?
A Or a combination of both or -- what -- or whatever.
Q Or a combination of the both --
A Yeah, whatever.
Q -- because you can have accidental trauma and non-accidental trauma?
A Yes, yes.
Q Okay. And -- and so in that case, you would be

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BY MR. HOOD:
Q And it says: "This policy statement relates to the issue of awareness detections and management of children at risk for abuse or neglect in the inpatient physician office and urgent care settings. It provides guidance on the procedure that should be followed in cases of suspected abuse or neglect."
You see on the summary statement, it's on the very first page?
A Okay.
Q And this is a policy at Carolinas Healthcare System of which Levine Children's Hospital is a part; right?
A Yes.
Q And then under "Definitions" it says, "Juvenile: Any person under 18 years of age who is not emancipated by marriage, court order, or a member of the Armed" Service -- or of the Armed "Forces." You see that; right?
A Yes.
Q And that be would be -- Owen C[redacted] would fall within that definition; right?
A Yes.
Q Then it has "Abused Juvenile: A juvenile

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whose parent, guardian, custodian or caretaker inflicts or allows to be inflicted serious physical injury which causes or creates a substantial risk of injury, death, disfigurement, impairment of physical health or loss of impairment of any bodily organ."
You see that definition; right?
A Yes, I see the definition.
Q But -- but you have said you couldn't rule in or out whether that occurred or not?
A True. I could not rule in or out whether Owen Carduff was abused.
Q Okay, okay. Then I go to the second page, which is "Procedure." And it says, "A. Clinical team identifies child abuse or neglect is suspected and initiates suspected child maltreatment inpatient order set followed by discharge order set if applicable."
A Yes.
Q Do you see that?
A Yes.
Q Now, that says, "Clinical team identifies child abuse or neglect is suspected."
A Yes.
Q You suspected it at one time, didn't you?
A Yes.

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Q And you initiated child maltreatment inpatient order set; right?
A Yes.
Q And a CHS clinical care management social worker did aid in the assessment process; right?
A Yes.
Q And a -- and a child abuse and neglect form was filled out on this case; right?
A Actually, it wasn't completely filled it out because it wasn't -- that's a form that's used on admission. So all the information that is required to be put in that form had already been gathered before.
Q Okay. But -- but they had filled out part of it but not all of it; right?
A Yes.
Q And why wouldn't they have filled out the rest of it?
A That scan form is an admission set. The patient had already been admitted, and it wasn't until after admission the injury was identified.
Q Okay. Well, I was also looking for the scanned discharge order form. Was there a scanned discharge order form that was used?
A I am not sure if that was completed.

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Q Okay.
A I don't know.
Q It says, "All cases of suspected abuse or neglect should be reported to the Department of Social Services in the county where the child resides."
Do you see that?
A Yes.
Q And you-all called York County Department of Social Services; right?
A Yes.
Q And, in fact, law enforcement was involved as well?
A Yes.
Q And then under 6 it says, "If a parent, guardian or caretaker refuses to authorize necessary medical treatment refer to administrative policy."
You see that paragraph; right?
A That --
Q Number 6?
A Yes.
Q But that didn't apply in this case --
A Right.
Q -- because they didn't -- they consented to all of the statements?

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I was not able to determine whether it was accidental or non-accidental trauma.
BY MR. HOOD:
Q Right, and I get that.
But what I'm saying is hypothetically, and I'm not even saying Owen C[redacted], let's just say any child, if you had said with the same -- everything else that Owen C[redacted] had, but you said, it's my opinion that the child suffered subdural hematoma because of the non-accidental trauma, based on your experience, more than likely not, they wouldn't have discharged the child home with the parents?
MR. TODD: Objection.
MR. FRAWLEY: Objection.
THE WITNESS: But every case is different. The constellation of signs and symptoms and everything that puts together in the case is different. So I'm not quite sure I how I could answer your question honestly.
BY MR. HOOD:
Q Sure. And -- and -- and, listen, I appreciate that.
A Okay.
Q I'll -- I'll ask it this way: Your

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decision on what caused the subdural hematoma is going to be important information to determine the disposition of the child to be discharged home back to his parents?
MR. TODD: Objection.
THE WITNESS: I guess I ready said, but I guess maybe I'm not communicating well. I was unable to determine how the subdural hematoma occurred.
BY MR. HOOD:
Q Sure.
A And so therefore, could not make a determination of whether it was accidental or non-accidental, because I couldn't determine how it was caused.
Q Okay. Even though you couldn't determine it, you still suspected it at the time of discharge though; right?
MR. TODD: Objection.
MR. FRAWLEY: Object to the form.
THE WITNESS: I -- I suspected --
BY MR. HOOD:
Q Non-accidental trauma?
A That that was a possibility.
Q Okay. Well, this whole child maltreatment

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thing happens because of suspected child abuse?
A Because it's a possibility, yes.
Q Okay. It's not because -- okay. It's just because of possibility, not probability?
A No, not probability, possibility.
Q Okay. And it's a possibility, the reason you do that in the case of a possibility is for the safety of the child?
A Yes.
MR. TODD: Objection.
BY MR. HOOD:
Q And the safety of the child is the top priority; right?
MR. TODD: Objection.
THE WITNESS: The safety of the child is always the top priority.
BY MR. HOOD:
Q And by being the top priority, you don't discharge a child home not knowing whether it's non-accidental trauma or not?
MS. BROOKS HOLMES: Objection.
THE WITNESS: I would not say that that's a true statement, in that you cannot determine in this particular setting of whether it was non-accidental trauma or not.

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The information was not able to be -- it's not like you could do a test for this.
BY MR. HOOD:
Q Sure.
A The information was not able to be obtained, what we had available at that time.
Q Okay. And then on the accidental, when we talk about the difference between accidental and non-accidental, I believe one thing you said earlier is -- and there's different ways it would happen, a child could fall off of something, could roll off, a child could -- they could shake it if -- if they were trying to dislodge food --
A Right.
Q -- and everything. Okay. Nobody ever said anything about the child needing to have something dislodged; right?
A Not in the history, no.
Q And no one ever said any -- this child at three months of age was not able to roll, crawl or walk.
MS. BROOKS HOLMES: Objection.
THE WITNESS: Was not able to.
BY MR. HOOD:
Q And what other way of accidental trauma

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a child three-months old is not able to speak to you; right?
A Yes.
Q It's hard to measure a child's cognitive ability at the age of three months; right?
A Right. Yes, I would say.
Q I know even with a CT access, a lot of times they don't make the diagnosis until the child is one or two years old; right?
A Right.
Q And so then, since the child can't help, you've got to look at the caregiver's explanation and see if it's supported by the characteristics of the injury; right?
A Yes.
Q The characteristics of this injury are you have a falx subdural hematoma, that is an injury pattern consistent with AHT, a second subdural, and they have no explanation for that; right?
A Yes.
Q So there was no supported explanation of the subdural hematomas, was there?
A There was no -- no -- nothing in the history which would give an explanation for them occurring.

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Q Okay. It says the -- going down to the bottom, "Clinical Presentation Settings," second full paragraph, "The clinical approach to an infant or child with possible abusive injuries is not significantly different than from standard pediatric care."
Do you see that?
A Yes.
Q And you agree with that; right?
A Yes.
Q "As with all patients, a severely-injured child must be stabilized before further evaluation is undertaken;" right?
A A critically injured child, yes. This child was not critically injured.
Q Okay. But in a child who has suffered an ALTE, apparent life-threatening event, once they are stabilized, a careful and well-documented history is one of the most critical elements of the medical evaluation; right?
A Yes.
Q "And if possible, you should document description of the mechanisms of injury or injuries and stated prognosis and progression of symptoms in the child's development capabilities;" right?

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A Yes.
Q And in this particular case, there was no description of the mechanism of the injury or injuries; right?
A Well, at that point there was no documentation that there had been an injury. The parents came in requesting evaluation because of the fact that he had cold symptoms, he had been seen by the pediatrician, and they felt that he was getting worse. He then had that choking episode at home and then was brought into the emergency room.
So at that point there was no injury really to document what the explanation or the mechanism was at that point.
Q Now, the subdural was a significant injury; right?
A He had a small subdural hematoma. I can't say how significant that -- the injury was that caused it.
Q You don't have an opinion about whether a -- two different subdural hematomas in a three-month-old child is a significant injury or not?
A Well, I can't tell you whether the -- the -- it's a significant injury. I can't tell you what

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the mechanism -- what the description of the mechanism of injury was.
Q Right, right. That's all I was doing, it's a significant injury?
A Right, yes.
Q Now, going under the medical history, it says, "Explanations that are concerning for intentional trauma include: One, no explanation or vague explanation for a significant injury."
Do you see that?
A Yes.
Q And that's something you have to take into your differential diagnosis, right?
A Um-hmm.
Q If you can give me a verbal.
A Yes, I'm sorry.
Q And explanation that's inconsistent with the pattern, age, or severity of injuries.
You see that; right?
A There was no explanation.
Q Right, right, there was no explanation.
A "There was no explanation."
Q It says, "Information should be gathered in a non-accusatory but detailed manner. Other information that may be useful in a medical

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about discharge plan and check with department of DSS referral status.
Q Okay. Now, when you do that, do you defer or do you delegate the checking with DSS to the medical social worker?
A She would probably make the call to DSS and depending on what the situation is, DSS may want me to be patched in when she calls, or they may not, depending on what the situation is.
Q Okay. But would you depend on her to be a liaison between you and DSS?
A Yes.
Q Okay. And then she could go back and tell them any conversation she may have had with you, likewise she could have told you about conversations she would have had?
A Right, yes.
Q Okay. If you go to the next page. And the first page, this is your handwriting; right? The page before that, that's your handwriting?
A This one?
Q Yes. And -- and when it's signed at the bottom, C and that's your hand -- that's your signature; right?
A That's my signature.

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Q Okay. If you to go the next where it starts "Notes planned peds attending."
A Yes, sir.
Q If you could read that.
A "Peds attending note. Extensive conversation with Morgan-Glenn and master's of social work regarding case. No etiology of subdurals revealed. Non-accidental trauma workup is negative. Eye exam is negative. No story forthcoming in explanation."
At that point, his anterior fontanelle was soft and it had decreased. It wasn't bulging -- it wasn't bulging anymore. The head cumference was the same, but it wasn't bulging. His lungs were clear. His abdomen was benign.
My impression was that he had a subdural hematoma. There was a question mark etiology. His non-accidental trauma workup was negative at the time. The plan was for DSS to follow family with home visits supervision cleared by master's of social work. Repeat skeletal survey in two weeks and follow-up with his PCP.
Q And that's primary care physician?
A Right, right.
Q Okay. And this would have been at 12 noon

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on 12/8/09?
A Or close to that.
Q Okay. And this would have been the discharge orders; right?
A No, this is my last note. This is my last note. The discharge summary is another document.
Q And it says, "Cleared by MSW."
A Right.
Q And when that says, "cleared by MSW," what does that mean?
A That means that we have a safety plan and the safety plan has been signed.
Q Okay. And is that supposed to be in the chart somewhere?
A It is in the chart, I think.
Q Okay.
A Usually. I don't place it in the chart, but it is usually -- that's usually where we find it.
Q Okay. If we go to Exhibit 23.
A Mm-hmm.
Q I can't read that on the top, what does that say "X-"
A Cross cover.
Q What is that?

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A That is the cross cover, which means that this person who wrote this, this was not their primary patient.
Q Okay. It says, "Patient with stable CT, DSS/SW okay to discharge with mom and dad."
A Mm-hmm.
Q DSS/SW, they are talking about the medical social worker here; right?
A Yes.
Q Okay.
MR. HOOD: That is Exhibit 23.
Let's have this marked as 24.
(Carolinas Healthcare System, H&P, 12/5/09 marked as Plf's Exh 24 for identification.)
BY MR. HOOD:
Q Doctor, on that last one I asked you about that entry, do you know who the X-COP person is?
A I don't recognize the handwriting. It's something that can be determined by looking back in the log who was -- who cross-covered.
Q Okay. And then we're looking at Exhibit 24, this is just the H&P on 12/5/09. I was just going to ask you one question.
You would been aware of the information contained in this record, when you began

EXHIBIT

"41"

State of South Carolina)
)
County of York)

Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen C[redacted] a minor,

Plaintiff,

vs.

Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, South Carolina Department of Social Services, Bruce Bryant, as the Constitutional Office of York County,

Defendants.

11-CP-46-04508

Video Deposition
of
Dirvondra Hill

Video deposition of Dirvondra Hill, taken before Kathleen R. Tackett, CVR, a notary public in and for the State of South Carolina, commencing at the hour of 9:58 a.m., Monday, January 14, 2013, at the office of McGowan, Hood & Felder, LLC, 1539 Health Care Drive, Rock Hill, South Carolina.

Reported by
Kathleen R. Tackett, CVR

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Also Present: Brooks Oswald, Videographer

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EXHIBITS

STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

Dirvondra Hill, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. HARRILL:

Q Good morning, Ms. Hill.
A Good morning.
Q My name's Lara Harrill. We met right before this deposition. Have you ever given a deposition before?
A No, ma'am.
Q Okay. Let's talk a little bit about the ground rules. I'm going to ask you some questions today

that I'd like for you to answer to the best of your ability. We do have the court reporter here. And, even though it's on video, if you could have all your answers be verbal, yes or no instead of uh-huh or unh-unh, it will be easier for her to take that down.

I have a tendency sometimes to want to talk over your answer with my next question. If you'll let me finish my question, I'll try and let you finish your answer. If I interrupt you, please stop me, okay?

A (Nods head up and down.)
Q If you need to go back at any time to another question, you're more than welcome to do that. Once the deposition has started, if you have any questions, I'd ask that you would direct those towards me as opposed to your attorney. Once the deposition has begun, you-all cannot discuss the deposition. Y'all can talk about the weather or whatever else but not about your testimony.
A (Nods head up and down.)
Q If you need a break at any time, please let me know. If you need for me to repeat or rephrase a question, please say so. I'll be happy to do that. If you answer a question, I'm going to assume that

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A With the --
Q And, we discussed earlier that that safety plan would have been the safety plan that was in place until you did yours on the 17th of December; is that fair?
A Yes.
Q And can you tell me what the safety plan says? Or what it -- according to your notes?
A What my safety plan says?
Q No. What that safety plan -- the safety plan that was put in place at the hospital that was in place until your safety plan on the 17th?
A "Parents not to remove the child from hospital against medical advice and until DSS determines" --
Q Okay.
A I don't know if it's "any more information." That's just --
Q Okay. I can pull that safety plan.
A Okay.
Q I can tell you it's not in these documents.
A Okay.
Q But, if you'll remind me on the next break, I'll pull it. We'll read the whole thing, okay?
A Okay.
Q But it is -- but is it fair to say that that's the

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safety plan that was in place for -- until your safety plan on the 17th of December?
A This is the safety plan that was in place, and, at that time, the agency got in contact with Levine's and informed them that it was okay to allow the parents to -- the parents and the baby to be discharged or to allow Owen to be discharged.
Q Okay. So whose decision was that: to -- to allow?
A The agency's.
Q The agency's, i.e., DSS?
A The agency decision.
Q Okay. So DSS's decision?
A Yes. DSS.
Q And what input does the hospital have into that decision? I mean, just in your experience.
A The hospital provided us the information regarding the parents' cooperation and what was going on with the baby at that time.
Q Okay.
A And any concerns that they might have had --
Q Okay.
A -- for us to address. And, at the time, could not determine if it was non-accidental or accidental.
Q You've been working for DSS since 2009, you said?
A 2007.

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Q I knew it was either '7 or '9. Have you had any other cases with children that had subdural hematomas?
A Not to my knowledge.
Q Okay. When you have cases where children are in the hospital, do you staff those cases with hospital staff?
A We do have a -- yes. We have -- it's a multidisciplinary agency meeting in which we do staff the cases now with the hospital staff, law enforcement detectives, anybody that's providing services to the family.
Q And when you said you do that "now," did you do that in 2009-2010?
A I cannot recall.
Q If you had, would it be in your dictation?
A It would be in the dictation if we did.
Q Okay. And would it be listed as a case staffing or what other actions might it be listed under?
A I do not know what action that would fall up under.
Q Well, if you do that now, what do you typically document that as?
A I cannot recall what that would be listed up under.
Q Okay.
A If that would be "collateral contact."

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Q Okay. Do you know whether or not -- or do you recall whether or not, related to this case, you were given any written warnings, reprimands, anything like that?
A I cannot recall.
Q Do you recall whether or not you had any discussions with your supervisor, either Krista Hinnant or Yvonne -- whose name escapes me. Her last name?
A Stewart.
Q Stewart. Yvonne Stewart. -- regarding timely referrals to law enforcement?
A I want to say yes.
Q Do you have any recollection of that conversation?
A I do not.
Q Okay. Do you know whether or not there was any documentation related to that?
A Documentation in regards to?
Q The -- whatever conversation you had about timely referrals or not-timely referrals to law enforcement?
A I cannot recall that information.
Q Okay. And do you know -- do you know how many other new cases you got that week, the week that the Owen Carduff case came in?

EXHIBIT

"42"

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State of South Carolina)
)
County of York)

Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen C[redacted], a minor,

Plaintiff,

vs.

Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, South Carolina Department of Social Services, Bruce Bryant, as the Constitutional Office of York County,

Defendants.

11-CP-46-04508

Video Deposition
of
Krista M. Hinnant

Video deposition of Krista M. Hinnant, taken before Kathleen R. Tackett, CVR, a notary public in and for the State of South Carolina, commencing at the hour of 9:56 a.m., Thursday, January 10, 2013, at the office of McGowan, Hood & Felder, LLC, 1539 Health Care Drive, Rock Hill, South Carolina.

Reported by
Kathleen R. Tackett, CVR

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For the Defendant Carolinas Medical Center: Monteith P. Todd, Esq.
Sowell Gray Stepp & Laffitte, LLC
1310 Gadsden Street
Columbia, South Carolina 29201

Also Present: Brooks Oswald, Videographer

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EXHIBITS

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

Krista M. Hinnant, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. HARRILL:

Q Good morning, Ms. Hinnant.
A Good morning.
Q My name's Lara Harrill. We met right before this deposition. Have you ever given a deposition before?
A No, ma'am.
Q I'm going to go over the rules with you.

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A Okay.
Q Although I know someone has probably done it. First thing is, since we have a court reporter here, she's trying to take down everything we say.
A Right.
Q I have a tendency to talk over people. If you'll let me finish my question, I'll try and let you finish your answer.
A Okay.
Q If I interrupt you, please stop me.
A Uh-huh.
Q I want to make it clear for her. Even with the videographer, it's harder for her to get everything on the record.
A Okay.
Q If you will say yes and no instead of nodding your head --
A Yeah.
Q -- or saying uh-huh or unh-unh, that'll make it much easier for her as well. If you have any questions during this deposition, I'd asked that you direct those questions to me rather than to your attorney.
A Okay.
Q If you do not understand my question, please ask me

EXHIBIT 42

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A Yes.
Q Typically, how long does that take?
A To receive medical records, once we have a release of information, it would depend on the facility. Some would copy them and give them to us right then. Some would make us do a formal request, and then send them to us.
Q And it takes a lot longer.
A Yeah.
Q Okay. Do you recall whether you or any of your caseworkers talked to doctors or nurses in this particular case?
A Yes. Dirvondra did speak with nurses, as well as Chandra -- Chandra Tyler spoke with a nurse and also the social worker. I believe Dirvondra had some contact with a doctor as well.
Q I may have already asked you this: Does the hospital typically -- and it may be either hospital. I -- it -- we could be talking about PMC, we could be talking about Levine's --
A Okay.
Q -- but, in your experience, if they have -- if they believe there's abuse, do they call you first, or do they call -- you being DSS?
A Yes.

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Q Or do they call law enforcement first?
A Typically, they would contact DSS first.
Q Okay. And what role did they have in DSS's investigation?
A Can you repeat that, please?
Q What role does the hospital have in your investigation?
A Well, we would certainly interview them and take into consideration any concerns that they have.
Q Do you look to them to help you make your case decisions?
A Yes. Absolutely.
Q And what happens when you have a case where the hospital is not sure whether there's abuse or neglect? Who makes the decision then?
A Then we would staff it as an agency and make it as a -- a group.
Q And, when you say "staff as an agency," who would be involved in a staffing like that?
A It would be, typically, our attorney, myself, Ms. Ward, and the caseworker. And maybe law enforcement, if they're involved, as well.
Q And would you have any of the medical personnel there?
A We -- typically, we didn't have them involved in

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our case decisions, but we would have their notes that we would use.
Q Okay. And do you rely on the medical experts -- or the medical expertise of doctors and nurses to help you make the decision whether or not a child has been abused?
A Yes.
Q Related to the first injury in this case, which was in -- which was, like, December 9th, 2009, was there ever a case decision made related to that injury?
A This --
MR. PRAWLEY: Lara, I think it was December 5th when he was hospitalized, December 6th when we got the call in.
MS. HARRILL: I apologize. You're right.
THE DEPONENT: That's correct.
Q Was there ever a case decision made related to that injury?
A Well, there was an ongoing investigation at that time. We made our case decision based off of both incidents.
Q Because you had, still, the 45-day window --
A And it was --
Q -- is that fair?

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A -- still an open investigation during the second incident. Correct.
Q Okay.
MS. HARRILL: I don't know if everybody knows how I do this. I know Monty does. The tab numbers are the exhibit numbers. And then I'll also give a Bates number. There's only one document in here that has not been Bates numbered, to my knowledge. But it has page numbers. Okay?
MR. PRAWLEY: Okay. Thank you.
Q I want to look a little bit at the dictation in this case, which is Tab No. -- Exhibit No. 4. How often do you print these to put in the file?
A Typically, they're not printed until they're transferred.
Q Okay. So when the case leaves your -- I'm -- I call it a "unit," but that's just for my experience --
A Yeah.
Q -- but when it leaves your office, it -- you would print the dictation to send the file down to --
A Down to treatment or foster care, wherever it would go, yes.
Q Understand. And, in this particular case, there

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A Uh-huh.
Q Yes. -- to your deposition. On the second page of those notes, it says, "Nurse thought DSS was called to release sitter."
A Yeah. That's in --
Q Would you tell me what that's about?
A I'm sorry. That's in Chandra Tyler's dictation.
Q Okay.
A A nurse told her that they were not supposed -- she was under the assumption that there weren't any concerns of abuse or neglect and that they were primarily contacting DSS in order to release the sitter that was in the room. And I guess that's something that North Carolina does; that's not something that South Carolina DSS does.
Q That was my next question.
A Yeah.
Q Your DSS wouldn't typically go and --
A We wouldn't have --
Q -- be a sitter?
A -- done that anyhow, no.
Q Okay. But that was Chandra Tyler?
A Yes. That would've been in her dictation.
Q And these notes are just notes that you took as --
A Yeah. As I read through the dictation, and things

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that I remembered, yes.
Q Okay. I want to look at them. Turn to page -- Tab 17, for me, please. And this conversation is actually -- appears to be January the 12th, also transcribed conversation between you and Lieutenant Miller --
A Correct.
Q -- is that fair?
A Uh-huh.
Q If you look at -- this one is a little harder to read because you-all were doing what I do and you were talking over each other. But -- so feel free to read this as I'm on Page 3. I'm looking specifically at Line 17, where you said, "They -- they wouldn't make a -- they wouldn't make a statement whether or not it was accidental or non-accidental." If you want to read that whole page to put that in context, I'm fine with that.
A I'm familiar with it.
Q Okay.
A Uh-huh.
Q Who -- and I may have asked you this before, who decides whether or not you indicate your cases at DSS?
A We do it as a group. This particular case would've

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been an attorney staffing case decision.
Q Why this particular case?
A Because we -- based off of the second incident.
Q Okay. But, with the first incident, would it have been an attorney decision?
A Probably -- maybe not. Phyllis could've been present for that. It would've depended on who was available: either Phyllis or Adrian or the other attorney that we had.
Q As a supervisor at DSS, how much difference does it make to you whether the hospital decides it was accidental or non-accidental in indicating your case?
A Can you rephrase that for me, please?
Q Rephrase it or repeat it?
A Repeat it. That'll be fine. Let's see if I can. . .
Q As a -- as a social worker --
A Uh-huh.
Q -- as a supervisor --
A Right.
Q -- how much difference does it make to you what the hospital's decision is in whether or not you indicate your case?
A Oh. We would -- if they had concerns that it was

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non-accidental, we would've indicated our case.
Q And if they have -- if they don't have concerns that it's non-accidental, does that mean you would not indicate your case?
A Not necessarily. If there had been something else that was of concern, we may have still indicated our case.
Q Do you -- excuse me. Do you know whether or not there was anything else that was of concern?
A Well, there were concerns that the parents were young and that they were immature and, maybe, concerns of lack -- lack of supervision.
Q What all can you indicate your cases for?
A Neglect, physical abuse, and sexual abuse.
Q What about threat of harm?
A You can do that, too. Threat of harm of each.
Q Okay. But, in this particular case, the second incident happened before your original case was determined, correct?
A Yes.
Q Turn to Page 4 for me, please, on your -- in Tab 17, Line 24. And if you'll read over to the next page --
A Uh-huh.
Q -- to Line 3. And you say, "We've got some

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Dirvondra?
THE DEPONENT: That's the one for Dirvondra, and Chandra Tyler is 0464.
MR. FRAWLEY: And the Chandra Tyler was the initial one?
THE DEPONENT: Correct.
MR. FRAWLEY: I'm sorry, Monty.
MR. TODD: Okay. That's okay.
THE DEPONENT: (To Mr. Todd) Do you want this?
MR. TODD: Now, that will be the exhibit -- we'll get that to the court reporter.
Plaintiff's Exhibit Number 22, "Release of Information"; "Safety Plan"; "South Carolina Department of Social Services Acknowledgement."

Q. Now, is -- am I correct that DSS made the decision that the child should be discharged on -- in December 2009, from Carolina's Medical Center back into the custody of -- of his parents?
A. Based off of the information that we had at the time, yes.
Q. And the information you got from the hospital -- and I know there was a number of discussions, but to -- to summarize it, what they told you was -- is

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that, "There's a concern for non-accidental trauma because of some of the findings, but we cannot make a definitive statement whether it is or whether it is not accidental or non-accidental"?
A. That's correct.
MR. TODD: That's all I have. Thank you.
THE DEPONENT: Okay.
MR. FRAWLEY: Okay. I've got a few questions.
THE DEPONENT: Okay.

EXAMINATION

BY MR. FRAWLEY:

Q. If you could refer to Number 16 -- Exhibit Number 16 --
A. Uh-huh.
Q. -- which I believe is the transcript of the December 17th conversation with Lieutenant Miller. Are you there?
A. Yes.
Q. Okay. December -- or Exhibit 16, of course, is -- are some excerpts from that conversation, and then Ms. Harrill has provided us with full copies of -- of those transcripts. And Exhibit 16 begins with this cover page, and then the first transcript page is actually Page 6; is that correct?
A. Yes.

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Q. All right. I'm handing you a copy of the full transcript of the December 17, 2009 conversation. Beginning on Page 5, Line 20, if -- I guess, for the record, if you'll read the Krista statements and then I'll read Lieutenant Miller. Maybe we can make it go --
A. Okay.
Q. -- more quickly that way. Starting with Line 20 on Page 5, can you tell me what that says?
A. Yes. "The hospital is not going to make a statement whether or not they feel as if that -- those injuries are accidental or non-accidental, period."
Q. "Okay."
A. "I staffed it with our attorney, and we let the child go home because the hospital's not making" --
Q. Okay. Then go to Page 6 on Exhibit --
A. -- "any determination."
Q. -- 16, please. Okay.
Lieutenant Miller then says, "Right."
A. "And they're saying they don't know what happened, and the hospital says mostly they have concern for lack of supervision."
Q. "Uh-huh."
A. "They think that maybe nobody was supervising him

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and he bumped his head or they were holding him and walking him around the door and banged his head or something. But they're -- they're really not giving us a whole lot. You know how they won't make statements."
Q. "Uh-huh."
A. "Because that was the first thing I asked him. And what happened is the social worker made the report on this, and the doctor did not advise the social worker --"
Q. "Right."
A. "-- to make the report. They feel -- real clear to me that I caught -- they feel -- they made that real clear to me when I called and spoke with them at the hospital, but I should have dictation on where, you know, I spoke with them. I can, you know, certainly send you that."
Q. Okay. And Ms. Harrill asked you questions about Page 6 -- about some context questions, because it wasn't clear from Page 6 what that was. But what you're telling Lieutenant Miller on Page 6 and the portion of Page 5 which we just covered is you're basically telling him what the feedback was that y'all had gotten from the hospital social worker when you spoke with them --

EXHIBIT

"43"

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF YORK)

ELIZABETH HOPE RAINEY,)
AS THE APPOINTED GUARDIAN)
AD LITEM TO OWEN C[redacted])
A MINOR,)
)
PLAINTIFF,)
)
-VS-) CA NO. 2011-CP-46-04508
)
CHARLOTTE MECKLENBURG)
HOSPITAL AUTHORITY D/B/A)
CAROLINAS MEDICAL CENTER,)
SOUTH CAROLINA DEPARTMENT)
OF SOCIAL SERVICES,)
BRUCE BRYANT AS THE)
CONSTITUTIONAL OFFICER OF)
THE SHERIFF OF YORK)
COUNTY, THE YORK COUNTY)
SHERIFF'S DEPARTMENT AND)
YORK COUNTY,)
)
DEFENDANTS.)
_____)

DEPOSITION OF REV. LARRY WILLIAMS
ROCK HILL, SOUTH CAROLINA
OCTOBER 25, 2012

REPORTER: SHIRLEY DALLAS-GERRALD, CVR-CM

DALLAS REPORTING
SERVING THE CAROLINAS FOR OVER TWENTY-FIVE YEARS
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Deposition of Rev. Larry Williams, taken before me, Shirley Dallas-Gerrald, CVR-CM, a Notary Public for the State of South Carolina, in the law offices of the Shaw Law Firm, Rock Hill, South Carolina, commencing at 10:05 a.m. on October 25, 2012 in accordance with the South Carolina Rules of Civil Procedure.

It was stipulated by and between Counsel for the Plaintiff(s) and Counsel for the Defendant(s) that this deposition is taken for any purpose allowed under the South Carolina Rules of Civil Procedure.

That the signing of the transcript of deposition by the witness is waived.

*****

Rev. Larry Williams, first being duly sworn, deposes and says as follows:

EXAMINATION - (By Mr. Todd)

Q Your name, please?

A Larry Williams.

Q **Mr. Williams, my name is Monty Todd, and I represent the Charlotte Mecklenburg Hospital Authority in a lawsuit that's been filed against them on behalf Owen C[redacted]. You've been listed as a witness in the case, and I understand you're married to Owen's grandmother.**

A That's correct.

EXHIBIT 43

A But we went once a week, maybe once a week, something like that.
Q And it'd be short visits - - -
A Short visits, correct.
Q - - - for you? And your wife was keeping Owen - - -
A Right. Right.
Q - - - during some parts of the week?
A Right.
Q But with you it'd be a short visit?
A Correct.
Q But would there be times when Owen and Kayla and Michael would come to your house and stay for awhile?
A Sure. Sure, they would come and we would have dinner together and play board games together and, yeah, hang out.
Q When you were observing Michael and Kayla around Owen did you ever see anything that made you suspect that either one of them might cause some harm to Owen?
A Never.
Q Did your wife, Charlotte, did she ever confide in you that she had some concerns that Michael might somehow harm Owen either intentionally or

unintentionally?
A No.
Q Did you ever have any concerns about Kayla or Michael's parenting skills?
A No.
Q Now, did you ever go to any of Owen's doctor visits?
A No.
Q Do you know who his doctors were in December? I think December the 4th of 2009 he went to the ER at Piedmont and then was transferred to Levine's in Charlotte. Did you go to any visits to Sunshine Pediatrics or to Riverview when Owen went in November?
A No.
Q Did you get any information about those visits or how Owen was doing?
A Yeah. Yeah, I got some information from those.
Q Do you remember anything about what you learned?
A Well, I think one time they said that he had strep throat or something like that and that they were treating it. And I knew that Owen was crying a lot. I don't know if he had colic or what, you know, at that time but he did cry a lot at that time. But not a whole lot of information.

Q Now, when Owen was taken to Piedmont on December the 4th 2009, did you go to Piedmont with your wife? I understand she was there.
A No, I didn't go.
Q Sometime during the night or early morning of December 5th did you learn that Owen had been transferred to Levine's in Charlotte?
A Yes, sir.
Q What did you learn?
A I learned that they had transported him by ambulance to Levine Hospital, that Charlotte had said that they had found some - - - some blood behind his eyes or something and that they really didn't know what was going on. And then I prepared to go to Levine to the hospital.
Q Do you know what time you got that call?
A From Charlotte? It was probably late in the evening, later on towards late evening probably.
Q And I could be wrong. I only to get to ask questions, I don't get to testify. My understanding is they went to - - - and this may, may not be right or not. But my understanding is on the 4th, like the late afternoon of the 4th or evening of the 4th, they went to Piedmont.
A I recall that, you know, it was probably somewhere

around 4:30, 5 o'clock maybe because - - - or right at getting dark because I remember I was putting Christmas lights up on the house at that particular time when we got the phone call, and I had to get my stuff together. And I had my kids so I had to make sure my kids were taken care of and all that before I even could make a move to go. So, yeah, it was probably late evening.
Q Did you go to Levine's - - -
A I did.
Q - - - on the 5th?
A I did.
Q Do you know what time you got there?
A It could have been somewhere around 10:00 or 11:00 maybe. Yeah, it had to be late because I know when you go - - - I know when you go to Piedmont you're going to be there three or four hours or better.
Q So we're going to put that down as a guess - - -
A Yes, it would be - - -
Q - - - to what time.
A - - - it would be the evening, - - -
Q All right.
A - - - late evening.
Q Where was Owen when you got there? Was he in a room, was he in the ER, or do you know where Owen

A Correct.
Q And so how often would she be keeping Owen?
A Sometimes it was like every other day. It even got to the point at one time I told Charlotte that she needs to tell Michael no, that he needs to be a responsible dad and take on responsibility himself. And then we - - - she did that. And then after the second incident, I felt really bad because I felt like I pushed him - - - pushed her into that, making that decision. And it was - - - so if I had any inclination at all that Michael was harming that child I would have never ever told her to make him take care of that child. So I have to live with that.
Q Do you know how long he was gone before Kayla let him come back or allowed him to come back?
A He may have been gone a week maybe.
Q And did your wife keep Owen that entire week?
A Pretty much while Kayla worked. Yeah. Yeah.
Q Do you know whether or not your wife had any action with DSS between the December hospitalization and the January hospitalization at Levine's?
A The December and the January?
Q Yes, after the - - - What I'm trying to find out is after Owen was discharged on, I believe it's

December the 8th, did your wife have any kind of contact or interaction with anyone at DSS?
A If she did, I don't recall it.
Q When did you learn that Owen was going back to the hospital in January of 2010?
A I was headed to - - - Charlotte and I were going to Columbia, I had to do a funeral, and just before we got on the interstate, on 77 south, he - - - I got a phone call and it was Michael on the phone and he was - - - I could tell he was very upset and he stated it's Owen, it's Owen, he's having seizures and I don't know what's happened and we're headed to the hospital. And I immediately turned around and went back to the house and Charlotte got her car and Charlotte went to the hospital. And I had obligations to this family to do this funeral, and I couldn't last minute just try to pull something together so I went on to Columbia and did the funeral. And then after the funeral was over with, I went to Levine.
Q Do you know what day of the week it was? It's was January - - -
A I don't - - - I don't recall.
Q Is January 10th - - -
A Okay.

Q When you got to Levine's what did you learn?
A When I had got to Levine, Owen was in intensive care, and he was hooked up to all these machines. And Charlotte was there. Kayla had already gone. I don't know if - - - I don't know if Michael and Kayla drove themselves to the jail, but I know that they were gone when I got there. And I knew that this was very, very serious.
Q I guess in the days of cell phones you probably had telephone calls from Charlotte as you were headed - -
A Right. Right.
Q - - - and did you learn that there was a concern about abuse?
A Yeah, I learned that they had airlifted him. The time before, he went by ambulance but this time he was airlifted to Levine. And, yeah, I realized it was very, very serious.
Q When did you learn that there was a concern about somebody having abused Owen?
A The second time.
Q Did you learn it when you were driving - - -
A Well, after - - -
Q - - - from the funeral, or did you learn it when you got there that night, or was it the next day?

That's just what I'm trying to find out.
A No, I learned - - - I learned it when I was - - - When I was driving to the funeral, Charlotte had called me and told me they were airlifting him. And she said it was bad. She said it was bad. And I really couldn't - - - I wanted to get this funeral over with as quickly as possible to get back to the hospital.
Q I'm not making my question clear.
A Right.
Q I understand you learned that Owen was in serious condition. But what I'm trying to find out, when did you learn that there was a concern that somebody had intentionally harmed him?
A After the second incidence.
Q Okay. When? Was it that first day?
A It was - - - it was that first day.
Q How did you learn about that?
A When I got to the hospital really and when I found out that they were taking - - - they had asked Michael and Kayla to come to the - - - to come to the Moss Justice Center. And then it was shortly after that, I think a few hours after that, they had a confession from Michael. And that's - - - that's when I knew definite that he was - - - he

was shaken.
Q Before that time, before you learned that Michael had confessed, did you suspect that Michael or Kayla or - - - Well, did you suspect that Michael had intentionally harmed Owen?
A Up until - - - up until the - - - until law enforcement had taken - - - till he had got a confession, I didn't know who had harmed Owen at that time. I didn't know, not until we got the confession. Once we got the confession then, yeah. And then on - - - on hindsight over here after the second incident, then looking back, looking back, there was some probably some signs there but we were just so involved in it, you know, so connected to it that we probably just missed those signs. I don't know. But on hindsight, after over here, you know, you realize then when you're over here, your grandchild has lost 75 percent of his brain activity, and his brain's swelling, and they've got tubes in him and got all this in him, then - - - then you're saying oh, my God, what - - - did I miss something, you know. But - - -
Q Well, in hindsight did you - - -
A - - - it was too late.
Q In looking back, was there something you think you

missed, even in hindsight?
A No. No, not really. Because - - - because the thing is is that - - - that we had - - - they showed no evidence. They showed no signs of physical abuse whatsoever, Kayla or him. If they - - - all of this stuff was done behind the scene to where - - - to where they just showed no signs. If they had showed some signs, if we'd have had - - - if we'd have had domestic violence or we'd have had - - - if he'd had showed some type of anger that he was capable of doing something like that, yeah, sure, but he didn't show any of that.
Q Do you know whether or not Michael had ever done anything to harm Kayla?
A No. No, she'd probably whip him. No, there was never any evidence of any kind of abuse on Michael whatsoever. Michael's more of a laid back person, and he was kind of quiet. Now, when we did have game nights and stuff he would open up and, you know, we would have fun and he would interact and stuff, you know. But Michael was more of a - - - he was more of a conservative type, you know. But, no, if we had any kind of knowledge that he was abusing his child in any kind of way, any kind of way.

Q So even in hindsight, you looking back, - - -
A Right.
Q - - - you couldn't even hindsight, - - -
A No.
Q - - - see anything that would - - -
A No.
Q - - - lead you to suspect that he would harm Owen?
A No. No. But truly feel bad about it afterwards, you know.
Q What about did Owen, did he have any - - - I'm sorry, did Michael, did you ever see anything that make you think that he might be doing drugs or alcohol?
A No, Michael never did drugs and never drank. Never. Never seen him do any of that. No.
Q Now, in January did you have any discussions with any of the doctors or staff about what had happened to Owen, about how his injury had occurred?
A Yes.
Q Who did you talk to?
A We were in the intensive care unit at that time and Dr. Bailey was there and there was probably a whole team of nurses and doctors and it was just - - - the room was just filled up with people. I remember Dr. Bailey being very, very angry at us,

all of us, like we had done something. You know, that - - - I don't know if he - - - I don't know if he was mad because Owen had returned to the hospital or he was mad because he missed it, the diagnosis. I don't know. But - - -
Q Did you talk to him?
A Yeah, but he was very gruff. He was very - - - we talked to him and he was very, very gruff with us with his answers and stuff. And they were really busy, really busy at that time trying to give Owen the best care that they could give him at that time and it was a lot of trauma. And it was just - - - it was a horrible, horrible thing to have to go through.
Q Do you remember anything Dr. Bailey said? You told me about his demeanor.
A Yeah. Yeah, he talked about his brain swelling. He talked about that it would swell to 75 percent. And he said if the brain did not begin to shrink that they would have to drill into his skull to relieve pressure which they had to do. And they had to go into his spine to relieve pressure there also. He talked about the condition of Owen that he may not make it through this. It was - - - it was just a very, very horrific time.

EXHIBIT

"44"

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF YORK)

ELIZABETH HOPE RAINEY,)
AS THE APPOINTED GUARDIAN)
AD LITEM TO OWEN C[redacted]
A MINOR,)
)
PLAINTIFF,)
)
-VS-) CA NO. 2011-CP-86-04508
)
CHARLOTTE MECKLENBURG)
HOSPITAL AUTHORITY D/B/A)
CAROLINAS MEDICAL CENTER,)
SOUTH CAROLINA DEPARTMENT)
OF SOCIAL SERVICES,)
BRUCE BRYANT AS THE)
CONSTITUTIONAL OFFICER OF)
THE SHERIFF OF YORK)
COUNTY, THE YORK COUNTY)
SHERIFF'S DEPARTMENT AND)
YORK COUNTY,)
)
DEFENDANTS.)
_____)

DEPOSITION OF CHARLOTTE WILLIAMS
ROCK HILL, SOUTH CAROLINA
JULY 20, 2012

REPORTER: SHIRLEY DALLAS-GERRALD, CVR-CM

DALLAS REPORTING
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Deposition of Charlotte Williams taken before me, Shirley Dallas-Gerrald, CVR-CM, a Notary Public for the State of South Carolina, in the law offices of McGowan, Hood and Felder, Rock Hill, South Carolina, commencing at 2:30 p.m. on July 20, 2012, in accordance with the South Carolina Rules of Civil Procedure.

It was stipulated by and between Counsel for the Plaintiff(s) and Counsel for the Defendant(s) that this deposition is taken for any purpose allowed under the South Carolina Rules of Civil Procedure.

That the signing of the transcript of deposition by the witness is reserved.

* * * * *

Charlotte Williams, first being duly sworn, deposes and says as follows:

EXAMINATION - (By Mr. Todd)

Q Your name, please?

A Charlotte Williams.

Q Ms. Williams, my name's Monty Todd and we met about a minute ago, and I represent Charlotte Mecklenburg Hospital Authority. It's Carolinas Medical Center, Levine's Children's Hospital. And this is my opportunity today to ask you some questions about a case that's been brought on behalf of Owen C[redacted]t.

A Yes, sir.

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you're related by blood or by marriage?
A No.
Q Now, I understand Mr. Williams does and we'll get that with Mr. Williams.
A Okay.
Q Had you had a chance to see Michael care for Owen before December 4th, 2009, before that first injury?
A Yes.
Q Tell me your impressions of Michael as a father.
A My impressions were fairly normal. He was a good father. He was there when he was supposed to be there other than financially.
Q Financially he's not working - - -
A Correct.
Q - - - well and not supporting financially.
A Correct.
Q I think Mr. Todd asked you did it appear that Michael loved him, and I think you said he was learning to love him.
A Correct.
Q Him would be Owen. As far as when he cared for Owen, did it appear to you that he was interested in caring for his child?
A I think that he cared for him when he had to.

Q I think Kayla mentioned he wasn't real big on changing diapers initially - - -
A Right.
Q - - - but, I mean, if diapers needed to be changed he could do that?
A Yes.
Q Did you have any concerns with how roughly he may have handled him? In other words, when the child was small, did you have concerns with Michael in the manner in which he would pick up Owen, maybe not hold his head properly when the head's not as strong as it might be?
A I remember telling him a couple of times remember to pick up his head, you know, because he's an infant.
Q Do you remember hearing Kayla correcting him on that sometimes?
A Yes.
Q Did you ever have to correct Kayla on that?
A Not that I recall.
Q Now, I think it was mentioned that you saw a bruise on Owen in November of 2009?
A Yes, sir.
Q And that was the dime-sized bruise? I think your best recollection was that it was on the left side of his head?
A Yes, sir.
Q Did you ask Kayla and Michael about that bruise?
A I asked Michael because he was with him that day.
Q Okay.
A Kayla was at work. And he explained that he had dropped the X-Box remote on - - - he dropped it out of his hands. Owen was apparently in the baby seat next to him.
Q And I think Mr. Todd asked you, you know, how is Owen otherwise, you know, the fact that he's got a bruise there that you saw and had concern about. Owen was acting appropriately at that point?
A Yes, sir.
Q Did you have any concern about the fact that Owen had a bruise on his head that was apparently inflicted when Michael was there? Did you have concern about Owen's safety when Michael cared for him because of that?
A No.
Q Were you concerned about Owen's safety before the first injury, December 4th of 2009?
A No.
Q While both of his parents may have been young and may have been in the process of learning

parenthood, you felt, before December 4th, 2009, that Owen was well cared for with the caveat that these were young parents?
A Correct.
Q Now, after the December 4th, 2009 injury and Mr. Todd went into and I think you answered how you found out about it and what your experience was with it. You understand that DSS was called into the case December 6th?
A Yes.
Q I mean, do you have an independent recollection of the date other than me suggesting it to you?
A No, sir.
Q But you know that some time after December 4th while Owen was still in the hospital DSS was called into the case, correct?
A Yes, sir.
Q How did you find out that DSS was called into the case? What was the first thing you found that DSS was involved?
A They came into the room.
Q At the hospital?
A Yes.
Q Do you remember the young lady who did that?
A I don't remember.

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Q You weren't shown any signs but did you have concerns?
A No.
Q You didn't have any gut feelings as a grandmother that the child was in peril?
A At that time I can't say I did. I know now - - - now, everything I know - - -
Q Right.
A - - - it's harder to answer that but at that time, no.
Q Now you've got a different prism that you look at those things now, - - -
A Exactly.
Q - - - that hindsight's 20/20 but - - -
A Exactly.
Q - - - but if the question is what you knew and when you knew it, as of the December 4th injury and before the January 11th injury, you had no reason to question that Owen was in good care with his parents, correct?
A Correct.
Q So you never relayed to DSS that you had any reservations about it, correct?
A Correct.
Q You do remember talking to Detective Amanda Carter

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after the second injury; in fact, it was the same day as the second injury, correct?
A Yes, sir.
Q And you were truthful with Detective Carter when you spoke with her, correct?
A Yes, sir.
Q Let's talk about stressors in Kayla's home at that time. Michael was not working after about October or November of 2009, correct?
A Yes.
Q And that was beginning to get to a point of stress for Kayla wasn't it?
A Yes.
Q Now, and you were very gracious with it, but you had reservations about Michael being your daughter's mate didn't you?
A Yes.
Q You thought that Kayla could do better than him, correct?
A Yes.
Q He played video games 24/7, and he wasn't working?
A Correct.
Q He was not a good provider?
A Correct.
Q So you had understandable reservations about that.

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That was a little bit of a stressor with Kayla because you, maybe were trying to be as discrete as possible, but a mother sometimes has to pass that on to her child whether intentionally or unintentionally, correct?
A Yes.
Q And at some point when you would raise an issue with Kayla, however discretely you were trying to raise it, Kayla at some point would say don't start, don't get into this now. She'd do that, right?
A Occasionally.
Q Not all the time because y'all had a close relationship.
A Correct.
Q But at some point she didn't want to hear anymore because that's her mate, and she's going to be protective of him, correct?
A Right.
Q But at some point the fact that this guy's just flat not working, she's working B shift every day at Walgreens, coming home and he's taking care of the kid while she's out working, at some point that because a stressor for her, correct?
A Yes.

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Q And it became a stressor for Michael too didn't it?
A I don't know.
Q Well, she kicked him out of the house New Year's Eve of 2009 didn't she?
A Yes.
Q So at least it got his attention as he's in the car on the way up to Concord.
A Right.
Q If you'd had a concern about Owen's well-being with Michael and with Kayla, did you know where the York County Offices of DSS were?
A No.
Q Did you know where the York County phone number was to call SC DSS?
A I would have found it.
Q If you'd had a concern, you would have lit up their switchboard; isn't that correct?
A Yes.
Q You talked to Mr. Todd about how you found out about the second injury, the January 11th injury, and what you did. And I think Mr. Todd asked you this, but I'll ask it again. After Owen was discharged back to Kayla and Michael December 8th, you had occasion to care for him some time after that didn't you?

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Q Does that help now refresh your recollection about what you may have discussed with Ms. Carter?
Mr. Frawley - Object to the form. Answer it if you can.
Q What does this help you do?
A It helps me understand more what happened or what I thought happened.
Q Now, they had each asked you about whether you had concerns at that time about whether Michael had hurt this child or you had suspicions about it and all this other stuff and you gave answers to them. And then you've also discussed that with Amanda Carter, right?
A Yes.
Q Now, how do you explain any type of concerns or suspicions that you had back in - - - Let me ask it a different way. I'm just looking at the top of this and it says the date of the interview was 1-11-10, right?
A Correct.
Q And on 1-11-10 he had come to the hospital, and he had seizures and was in bad shape, right?
A Correct.
Q And when he was in that kind of shape, what was your emotional state like at that particular time?

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A I wasn't even coherent. It - - - it was scary.
Q And in that emotional state when she spoke to you, do you recall saying, and I'm looking from just reading from this, I knew this was coming?
A I don't recall saying that. Clearly, I did.
Q Do you know why you would have said that at that specific time?
A Anger.
Q And why were you angry?
A I think this was taken the day that Owen was put back in ICU and I know - - - I remember just being angry, very angry that he was there and scared.
Q Now, when Mr. Todd asked you about whether you had concerns or suspicions, do you recall telling him no, I don't think I did?
A I know that I didn't have suspicions the week - - - or several - - - couple of weeks between the first incident and the second incident. I wasn't feeling it at - - - in the moment.
Q Was it only after he went to the hospital on January 11th, '10 that you began to have those suspicions?
A It all made sense then.
Q You used the term before all the pieces came together.

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A Exactly.
Q So when you were talking with Mr. Todd and these people about concerns and suspicions before, you were not talking about suspicions or concerns you had prior to January 11th, 2010 were you?
Mr. Todd - Objection.
Mr. Frawley - Object to the form. Answer the question.
Q You were only talking about suspicions you held from January 11th, 2010 on?
A Correct.
Q When you gave this particular response to Amanda Carter, right?
Mr. Todd - Objection.
Mr. Frawley - Same objection. Go ahead.
A I gave this response to Amanda Carter in complete emotional disarray. I remember that now. I remember that clearly.
Q Okay. And so on January the 10th, 2010, and January 9th, 2010, and January 8th, 2010, back to December 4th, 2010, did you know it was coming?
A I did not know it was coming. Nobody could have known that was coming.
Q Now, what about somebody - - I believe that Mr. Todd asked you do you hold Michael responsible for

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harming this child and you said yes, right; you recall that?
A I do.
Q Now, who were the professionals in this particular case?
A Meaning DSS and the hospital? Who do you mean?
Q Who were the people that are supposed to know that a child has been abused?
Mr. Todd - Objection.
Mr. Frawley - Object to the form. Answer the question.
Mr. Settana - Object to the form.
A It was my understanding that the doctors at Levine were indicating that there was possible abuse. They're the professionals. I'm just the grandmother. I know that I did not have concerns of anyone possibly abusing Owen during that time.
Q And then who were the people that were doing investigations, not CMC, but was it DSS and York County Sheriff's Department?
A My understanding, when we were released from the hospital December 8th, was DSS was going to follow up, meaning investigate, find out what happened to my grandson.
Q And if CMC and DSS and the York County Sheriff's

EXHIBIT

"45"

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF YORK)

ELIZABETH HOPE RAINEY,)
AS THE APPOINTED GUARDIAN)
AD LITEM TO OWEN C[redacted],)
A MINOR,)
)
PLAINTIFF,)
)
-VS-) CA NO. 2011-CP-86-04508
)
CHARLOTTE MECKLENBURG)
HOSPITAL AUTHORITY D/B/A)
CAROLINAS MEDICAL CENTER,)
SOUTH CAROLINA DEPARTMENT)
OF SOCIAL SERVICES,)
BRUCE BRYANT AS THE)
CONSTITUTIONAL OFFICER OF)
THE SHERIFF OF YORK)
COUNTY, THE YORK COUNTY)
SHERIFF'S DEPARTMENT AND)
YORK COUNTY,)
)
DEFENDANTS.)
)

DEPOSITION OF KAYLA LYTHGOE
ROCK HILL, SOUTH CAROLINA
JULY 20, 2012

REPORTER: SHIRLEY DALLAS-GERRALD, CVR-CM

DALLAS REPORTING
SERVING THE CAROLINAS FOR OVER TWENTY-FIVE YEARS
ROCK HILL, SOUTH CAROLINA
803-328-9640/TOLL FREE 1-877-871-6363

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Deposition of Kayla Lythgoe, taken before me, Shirley Dallas-Gerrald, CVR-CM, a Notary Public for the State of South Carolina, in the law offices of McGowan Hood and Felder, Rock Hill, South Carolina, commencing at 9:53 a.m. on July 20, 2012 in accordance with the South Carolina Rules of Civil Procedure.

It was stipulated by and between Counsel for the Plaintiff(s) and Counsel for the Defendant(s) that this deposition is taken for any purpose allowed under the South Carolina Rules of Civil Procedure.

That the signing of the transcript of deposition by the witness is reserved.

*****

Kayle Lythgoe, first being duly sworn, deposes and says as follows:

EXAMINATION - (By Mr. Frawley)

Q Ms. Lythgoe, will you state your name and address for the record, please?

A Kayle Lythgoe. You said address?

Q Yes, ma'am.

A 2799 Whiskey Road, Aiken, South Carolina.

Q Have you ever had your deposition taken before?

A No.

Q Let's go over some preliminaries. I introduced myself to you a moment ago. My name is Pat

EXHIBIT 45

how he was tolerating the formula?
A No. No change.
Q So he adapted pretty well from breast milk to formula?
A Yes.
Q Describe Michael as a father for me in those first few weeks. Was he attentive, was he kind of worried about holding the child; how did he appear to you to be?
A He seemed pretty confident with holding him.
Q Okay.
A Like any typical man, he never wanted to change diapers.
Q I used to like changing diapers, but go ahead.
A That's rare. He was comfortable with him. He did get nervous when he had to be alone with him, but I found that to be normal.
Q Would he get spooked if he's alone with him holding the child and the child suddenly gets fussy or starts crying?
A No. He would burp him or - - - and after he burped him and couldn't figure it out, he'd usually just bring him to me.
Q Okay.
A But for the most part he seemed fine with him.

Q And how did Owen appear to react or respond to Michael when Michael held him?
A Natural.
Q Owen made eye contact with him?
A Yes.
Q Now, I read somewhere where your mother never really warmed up to Michael, would that be an accurate statement?
A Yes.
Q She thought you could do better?
A Yes.
Q And at some point Michael lost his job, correct?
A Yes.
Q When did he lose his job?
A It was after Owen was born. I would say probably around October-ish.
Q It would have been certainly before the December 4th first hospitalization, first injury, correct?
A Yes.
Q So at the time of the December 4th first injury - - - and I'll refer to them as the first injury which would be that December 4th through December 8th hospitalization, then the second injury which is the January 11th injury, all right?
A Yes.

Q Michael had lost his job before the first injury, correct?
A Yes.
Q Was your mother's attitude toward Michael, did that create any stress between you and Michael?
A A little.
Q I mean, did Michael know that your mother did not hold him in high regard?
A Yes.
Q Did they get along okay when they were together?
A Yes.
Q Now, you mentioned a moment ago how Michael was with Owen. Did you notice on occasion that he would be rough with Owen or not as gentle as you would have thought he should have been in picking him up?
A Yes.
Q Describe that for me.
A It was non-aggressive, no anger in it, just he would sometimes maybe forget to support his head or he would swoop him up super fast instead of slowly. He would just stand upright. And then when he got a little older like two-ish, three months old, he would, you know, kind of do the up and down and that scared me.

Q Okay.
A But other than that, it was nothing else.
Q Initially, it would have been from your perspective just that he wasn't aware of how fragile a child could be?
A Right.
Q And didn't always support his head as much?
A Right.
Q And later on you said he would maybe, I mean fathers do this, bounce the kid on their knee or something but a little bit more than you thought maybe would have been appropriate - - -
A Right.
Q - - - or at least you were worried about it?
A I was worried about it, yeah.
Q Okay.
A It just scared me.
Q On those occasions when he would, and I think you used the gesture of your hands - - -
A Yeah.
Q - - - as if they're holding a baby going up and down, - - -
A Right.
Q - - - how would Owen appear to be responding to that?

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A Oh, he loved it.
Q The kid looks like he likes it - - -
A Yeah.
Q - - - but you're thinking well, maybe this isn't the best thing?
A Yes.
Q Did you ever see Michael drop Owen?
A No.
Q Did you ever see - - - well, between his September birth and the December 4th first hospitalization, Owen wasn't even standing up in the crib yet was he?
A No.
Q I mean, could he even turn over?
A Yes.
Q Did you ever see an occasion when he would turn over and hit the side of the crib?
A No, he wasn't that advanced.
Q Okay.
A We just have it on camera once him rolling over.
Q When you put him on the floor, would he crawl; was he to that point yet?
A He did the back and forth thing.
Q Back and forth.
A He wouldn't go anywhere, but he'd like get up and

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then down.
Q Kind of rock - - -
A Yeah.
Q - - - forward and backward, okay, - - -
A It's very cute.
Q - - - which is a precursor to crawling. You mentioned you had him on the camera. Tell me about that. What kind of camera did you have?
A Michael's mother gave us her video recorder. It did it on the little mini DVDs and we recorded everything, absolutely everything.
Q Do you still have those videos of Owen?
A I do.
Q And do any of those videos show Michael with Owen?
A Yes.
Q And those would be obviously from some time in September up through - - - would you have videos that were taken prior to the first injury?
A Yes, we have him coming home, and we have just random things that would be boring to everybody else, and then we have him rolling over and Christmas and all.
Q Had he ever gotten to where he could sit up if you put him in a couch where he could sit up?
A No, not unsupported.

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Q No? Okay. Where he sits up and then you watch him in the video and he just sort of, okay, - - -
A Yeah.
Q Did you and Michael - - - I guess once he lost his job and as we're getting into December, was the fact that he was not working and you were working, did that become a source of stress for the two of you?
A Yes.
Q Was he out looking for other jobs?
A No.
Q With Food Lion, why did he leave that job?
A I remember there was something to do with it like he asked off for a day to go up to Concord to see his parents and then he like never went back. I don't really remember what had happened. I'm trying to remember if it was because of Thanksgiving, did we take off for Thanksgiving and then he just never went back, but I'm not okay with the dates there.
Q Okay.
A But something like that happened, he just slacked off.
Q And I think I asked a moment ago, and I'm not holding you to this, but I think a moment ago you

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mentioned that he may have left his employment some time in October but it may have been as late as November when that happened, - - -
A Yes.
Q - - - at or around Thanksgiving possibly?
A Yes.
Q Did he ever tell you why he left the job, whether he was fired or he just stopped showing up or - - -
A He just - - - well, he didn't like his manager and he would always complain about how he hated him and how the manager hated Michael.
Q Do you know who the manager was; do you remember his name?
A I think it - - - it was an M definitely. I think it was Mark or Mike.
Q Mark or Mike.
A Yes.
Q Was he an older guy or - - -
A No, younger.
Q - - - younger guy?
A And nobody liked Michael professionally because he refused to cut his hair, another just defiant thing about him.
Q How long was his hair?
A Long. It was to his shoulders, a little past.

Q **Not as long as yours?**
A No.
Q **Okay.**
A No, I wouldn't have that.
Q **When he would go to work would he tie it back or - - -**
A Yes.
Q **Okay.**
A He always had it back, bottom was shaved off kind of thing.
Q **Now, I know he had a tattoo on his leg?**
A Yes.
Q **Did he have any tattoos on his arms or anything that would be visible?**
A No. That was very recent too.
Q **When he left Food Lion for whatever reason - - - do you know if he was fired or if he just left?**
A I'm pretty sure they fired him by not showing up.
Q **But he never told you that?**
A No.
Q **And he never had a day where he went to work and they said you're fired, go home?**
A I don't believe so.
Q **As far as you know he just stopped showing up and they just took him off the payroll?**

A Yes.
Q **Okay.**
A I believe that's how it went down.
Q **After he left Food Lion, did he go, to your knowledge, for any other jobs?**
A No.
Q **So he never even applied for another job after that?**
A He got very lazy.
Q **Did he tell you why he wasn't applying for jobs when he's the man in the house, he's got not yet a wife but the mother of his child and a young child, did he tell you why he's not out there trying to earn some money when you're working B shift 40 hours a week?**
A No, he just would say, you know, well, I - - - I watch the baby and you go to work, that kind of thing, so.
Q **And what did you say when that happened?**
A I mean, we had conflict because of it. I would just - - - I would yell all the time, and he'd yell at me for being a nag and so it was just those - - -
Q **Did he ever hit you?**
A No.

Q **Did he ever threaten to hit you or ever get physical right in your face?**
A No.
Q **You weren't afraid of him?**
A No.
Q **Let me ask you this, this happens frequently when couples get together, they live together for awhile, then they have a child, and then afterwards their intimacy gets affected. I'm not - - - I don't want to go into any detail, and I apologize for any embarrassment, but did your relationship with Michael change after the child came?**
A No.
Q **So you were as intimate after the child came as you had been before?**
A Yes.
Q **And I apologize for getting into that.**
A That's okay.
Q **Were there occasions, we mentioned earlier about Michael possibly being a little rougher when he would pick the child up when he was little, did you have occasion sometimes to tell Michael you need to be more careful?**
A Yes.
Q **And what was Michael's response to that?**

A Usually - - - well, it depended on what it was on. If it was because he was playing with him he'd be like well, he likes it or if it was because he'd picked him he'd say sorry and - - -
Q **I'll try to do better next time?**
A Yeah.
Q **Did you ever see his brother pick up Owen at any time when Brian was there and y'all were there?**
A Yes. Brian showed a lot of love towards him.
Q **How old was Brian?**
A He was older than me. I think he was 20.
Q **So he was Michael's older brother?**
A Yes.
Q **But was Brian working at that time?**
A No.
Q **Had Brian completed high school, do you know?**
A Yes. Well, no. No, I don't think he did. I'm sorry.
Q **Now, had you noticed that Michael would sometimes be rough in picking up Owen before that December 4th first injury?**
A Yes.
Q **And when you would see it you'd correct him on it?**
A Yes.
Q **And by that December 4th first injury was Owen of**

Q Did Michael have any kind of temper?
A No.
Q Did he ever get frustrated over stuff?
A Yes.
Q Did he get frustrated over the fact that he wasn't working?
A No, he got frustrated over the fact that I nagged him for not working.
Q He enjoyed not working?
A Yes.
Q When he didn't work and he stayed home, I mean, obviously, I guess he's saying he's watching the kid, but what else is he doing?
A He would go to Concord some times or - - - that's about it really.
Q When you wouldn't be working what's he doing?
A He's usually at home. He was a gamer, - - -
Q Games.
A - - - always playing games or shopping.
Q Okay, video games?
A Yes.
Q Okay. Or shopping?
A Yes, his parents gave him money a lot.
Q What did his parents do? Were his parents affluent?

A I'm sorry, what is that?
Q I mean, were they well off?
A Yes, to my knowledge.
Q Do you know what Mr. Carduff did?
A They were both in a Walgreens' business. I believe he was high up, you know, and - - -
Q And that's how they could assist you getting the job?
A Yes.
Q When you worked for Walgreens, what did you do for them?
A I started off as a cashier, and I transferred three times total. And when I found out I was pregnant, I left the Concord one because we left to go to my parents - - -
Q Right.
A - - - or closer to them - - -
Q Right.
A - - - and that's when I transferred to Rock Hill. When I was in Rock Hill, I got promoted to go do the photos, and I was head photo specialist and I made the photos and all that. Then we transferred again - - - Oh, well, yes, we transferred again to Aiken and there I was promoted to pharmacy.
Q When you were in pharmacy in Aiken, what did you do?
A I did the filling, counting pills, patient interaction. I called for authorizations and billing.
Q When you left Walgreens and went to your first non-Walgreens' job, I mean, were you dissatisfied with Walgreens or just looking for more pay?
A No, I was extremely happy with Walgreens. I was let go because when I got hired, when I was 17 when I first got the job, I marked that I had a GED when I did not and they found that out three years later.
Q Oh, okay.
A Very upsetting.
Q Now, in the interim, did you get your GED?
A Yes. Not while I was with Walgreens, it was afterwards.
Q So you basically got fired because you had on your application from when you were 17 that you had a GED when you really didn't - - -
A Yeah.
Q - - - and they didn't like that so they terminated you and then you subsequently did get your GED?
A Yes.
Q Tell me about what led up to the December 4th hospitalization and the first injury. Now, I understand you - - - that Owen was acting oddly, was, I think, sleeping all the time but when he was awake he was screaming a lot, correct?
A Yes.
Q Tell me how that came about, how you discovered that. I mean, did that just happen one day or was it something that developed? Was he sick and then that resulted; how did that come about? When did you begin taking him to healthcare providers?
Mr. Frawley - And I'm going to let you do a - - -
Mr. Todd - Objection.
Mr. Frawley - No, what I was going to say, I'm setting the stage and I'm going to ask specific questions.
Mr. Hood - Sure. Sure.
Mr. Frawley - I mean, that question, as I put it, it's easily objectionable. But what I'm telling you - - -
Mr. Todd - You should object to your own question.
Mr. Frawley - Yes, well, that's kind of where I want to go with this.
A Okay.

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Q Where do we start? When did you first notice it? And those are the questions that I'll ask.
A Okay.
Q And then I'm going to open the floor to you to do that. Now, at or around that time - - -
Mr. Settana - When you say that time, you're talking about December 4th?
Q I'm talking about between, say, Thanksgiving - - -
Mr. Settana - Okay.
Q - - - and December 4th, late November early December, was there a time in there where Owen had a cold, the flu, was sick, where that began where he went from a well baby to a baby that's got a runny nose and is cranky?
A Yes.
Q And tell me about that.
A He was fine during Thanksgiving and then he started to get the sniffles which I figured came with the season. But we checked him out for the sniffles and that's what we were told it was and not to worry.
Q And who told you that?
A Paxton.
Q Now, when you say Paxton, so he got the sniffles and what you did in response to that was instead of

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just, you know, hoping he sleeps through it, you took him to a healthcare provider, Sunshine Pediatrics, correct?
A Yes.
Q And the Paxton you talk about is Dr. Paxton, correct?
A Yes.
Q And Dr. Paxton told you what again?
A It's just a case of the normal sniffles.
Q And what was Owen doing at that time that led you to the conclusion that he's sick enough that you need to take him to Sunshine; what was he doing?
A He was just really runny and red in the nose, and that was it.
Q As far as his disposition, how was he acting?
A Fine.
Q Okay. I mean, happy or was he - - -
A Oh, yes.
Q Okay.
A Yes, happy.
Q All right.
A It was not until after that, a couple like about week now before the 4th, that is when he started to act really weird.
Q Okay. Well, let's talk about that.

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A Okay.
Q What was he doing that lead you to tag that today as being really weird?
A He would not - - - When he was up, it was constant crying.
Q Okay.
A Again, I'm a first-time mom. I don't - - - I've heard about colic so I just figured it was that so I let it go a little bit until, you know, the feeding got odd. He didn't never want to eat. We had to make him eat, not, you know, force or anything, but we had - - - it was a job to make him eat.
Q Okay.
A And we had to wake him up to eat. He wouldn't wake up to eat anymore. And I knew that was odd because I was told babies wake up, and he was prior, like every three hours to eat, and he wasn't.
Q Okay.
A So I got really concerned there. At one point he had a fever and so I took him - - - his pediatrician was closed so I took him to Riverview - - -
Q Riverview, okay.
A - - - I think it was called. It's like a 24-hour

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clinic.
Q Do you remember what day of the week this was?
A I do not.
Q It doesn't matter.
A And it was nighttime because it was after I got off work so we went up there. And I told the doctor, and they didn't make fun of me but, you know, calling me a first-time mom, and I'm worrying too much, and it's okay but to follow up with his pediatrician which I did. And he told me that it could be a throat infection and so I said okay. And he put him on some antibiotic.
Q Let's stop there a second. You went to Riverview and they didn't really make fun of you but they said first-time mom.
A Yes, which is fine.
Q Were they being dismissive of you or did you get the impression they're actually looking at him and trying to analyze what the problem is?
A I mean, well, he was crying, crying, crying when I brought him and of course, we went back, he was happy.
Q Okay.
A He was laughing.
Q Okay.

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the driveway as you're on your way out to work, did you tell her at that time that Owen was with his grandmother, in other words, his grandmother was caring for him that day?

A Yes. I had forgotten about that until you brought it up.

Q But with me having brought it up, that prompts a recollection, correct?

A Yes.

Q I mean, it did happen, right?

A Correct.

Q Now, the grandmother, was it your mom or was it Ms. Carduff with whom you were staying?

A My mother.

Q With Charlotte Williams?

A Yes.

Q And do you recall Ms. Hill asking you for a contact phone number so she could contact Ms. Williams and you were not able to give that phone number to Ms. Hill; do you remember that?

A Yes, sort of. I remember her asking me. I don't remember not giving it to her. I don't know why I would not be able to.

Q Where would Michael have been then that day?

A I don't know.

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Q In other words, why was your mom caring for the child instead of Michael?

A Michael - - - if it was morning he was probably asleep, but I'm not positive.

Q Owen would have been better cared for with your mother than with Michael anyway on that day wouldn't he?

A Yes.

Q Are you still good to go?

A Yes.

Q Give me a second. Some of these questions I've already asked. We don't have to go over them again. Okay. That takes us up to December 21st just before Christmas. Did y'all have a normal Christmas?

A Yes.

Q Now, within ten days after this December 21st home visit the issue with Michael and his not working, his not getting a job, reaches a head and you essentially kick him out of the house New Year's Eve; isn't that correct?

A Yes.

Q Was it on New Year's Eve, was it a day before, a day after?

A It was New Year's Eve.

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Q New Year's Eve. All right. Tell me how that conversation went.

A It was not good. His friends were there.

Q At your home?

A Yes. Another thing that upset me so much. I mean, that's what broke me to kick him out. Because I could tell he just didn't - - - Owen was more of a bother than a good thing when his friends were over. So I just - - - I went in there, my mom was with me, and I brought him to our room. I told him to come with me in the back and I said, you know, this is hard for me but you need to go, you know, you're not showing any incentive of being a man.

Q You need something to drink; you okay?

A Yeah, I'm fine.

Q All right.

A And I said you're being lazy, your friends are always here, this is not a party house, and blah, blah, blah, and just kicked him out. I said you need to go, you need to take your friends with you, and you need to go back to your mom's house because apparently that's where you need to be. And so he did. I mean, he didn't really fight it, but he just did it. He didn't say anything. And I just stood there while he packed all his stuff up and he

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left, and that was that.

Q You said that his friends were there on New Year's Eve. I mean, a lot of people are out partying New Year's Eve. He's got his friends over there. How many friends were there?

A Two.

Q Two.

A His brother Brian and his best friend Aaron.

Q And you said in your explanation there that his friends were always there. When you say - - - I know that's probably and overstatement - - -

A Yes.

Q - - - but, I mean, how frequently would you come back from working your shift, and he would be there with either his brother or his brother and others?

A It was always either just his brother or his friend or both of them. They didn't - - - It wasn't as - - - I should say they didn't come often. When they did come, they stayed so long. I'll state it like that.

Q Didn't know when to leave?

A Yes. So they would come like once a month for like a week or a whole weekend and it just bugged me because Michael would always stay up till like 4:00 in the morning and all that. It was just annoying.

March 18, 2013: Expert Opinion: J. Kevin Moore: Hospital Administrative Issues and Concerns
Case: Carduff v. Carolinas Medical Center. Client: McGowan, Hood & Felder, Rock Hill, SC 29732

FACTS

Owen C[redacted] a three month old boy, became ill on December 4, 2009 while in the care of his father. He was taken to the emergency department at Piedmont Medical Center (PMC) by his parents, admitted near 5pm, stabilized, and transferred to the Levine Children's Hospital (LCH) near 2:30 am on December 5, 2009. The first documented entries raising suspicions of child abuse appear in Owens record near 8:30 am on December 5th. Implementation of LCH child abuse policies and protocols immediately followed. Applicable policies required coordinated efforts by medical, clinical and social worker staff at LCH, and notice to the Department of Social Services in South Carolina (DSS), where Owen resided, to evaluate and assess potential child abuse.

From December 5th- 8th, 2009 LCH conducted medical examinations and tests finding 2 subdural hematomas, one of which was unexplained and potentially resulted from child abuse or non-accidental trauma. During the same time, LCH social workers provided medical findings and psychosocial assessments of the parents to DSS, discussed disposition issues including custody or supervision, and the requirement that a safety plan be developed and in place before discharge. Medical findings were insufficient to determine whether or not Owens injuries resulted from child abuse. On December 8, 2009 at 12:45 pm Owen was discharged to his parents. On January 11, 2010 Owen returned to LCH with severe traumatic brain injuries. LCH records indicate Owen's injuries were severe, resulted from child abuse, and will likely result in significant lifelong disability.

ANALYSIS

For purposes of this analysis, Levine Children's Hospital (LCH), Carolinas Healthcare System (CHS), and Charlotte-Mecklenburg Hospital Authority are considered as the defendants and referenced as LCH.

The question presented is whether LCH abrogated a duty or responsibility to Owen, and deviated from laws, standards, rules, regulations or its own policies thereby violating the standard of care by discharging Owen Carduff into the care of his parents, allowing for further injury. Based on a review of the court filings, patient records, LCH policies and procedures, and other documents my conclusion is in the affirmative.

LCH abrogated its duty to Owen and violated the standard of care.

The standard of care for patients who are suspected victims of abuse is broadly addressed by Joint Commission (JCAHO) 2006 hospital accreditation standards on Provision of Care, Treatment, and Services (PC). PC 3.10 requires victims of abuse be assessed, specific criteria be developed for Child Abuse cases and that appropriate staff is educated on how to address abuse cases. The JCAHO requires the Hospital develop and implement specific policies to carry out these standards. Those policies are the primary basis of my analysis and the standard of care the Hospital set for itself.

LCH Policy and Procedure require that any child age 0-6 months with **any** injury be designated as a patient "suspicious for child abuse". *(PR 110.03: Child Maltreatment Clinical Practice Guidelines: Evaluation and Management of Suspected Child Abuse or Neglect: Section I, Child Physical Abuse, Part A. Identification (1).002642)* Owen met these standards.

ANALYSIS (cont.)

Once so designated, a series of mandated LCH policies, procedures, protocols and practices are triggered purposed to "...provide guidance on the procedure that **should** be followed in cases of suspected abuse or neglect" ... *(P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: Summary Statement 002636).* Critical among those actions required by LCH policies are:

1. Notice to the Department of Social Services in the county where the patient resides. *(P.R. 110.03: Juveniles suspected of Being Abused or Neglected: Procedure (Procedure (A) (5) 002638.)*

2. Completion of the CHS Suspected Abuse and Neglect (SCAN) form. The SCAN form is primarily a medical evaluation tasked to identify any physical or clinical signs, symptoms, or injuries which could indicate or confirm child abuse through medical tests, evaluations, and consultation among physician specialists and clinicians. SCAN is designed to identify clinical manifestations of child abuse and determine if medical clearance can be attained **before** patient discharge can occur. *(P.R. 110.03: Juveniles suspected of Being Abused or Neglected: Procedure (A) (3) Complete CHS SCAN form. 002637)*

3. A psychosocial assessment of the parents and/or caretaker and environment in suspected child abuse cases evaluating if:

    a. The infliction or **allowing** the infliction of serious physical injury occurred while in the care of the parent, caretaker or guardian. *(P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: Definitions (B) (1) (a) 002636*
    b. The parent/guardian has logical explanation that is consistent with the age, pattern, and severity of the injury. *(PR 110.03: Child Maltreatment Clinical Practice Guidelines: Evaluation and Management of Suspected Child Abuse or Neglect: Section I, Part B. Essential Aspects-Caretaker History (1). 002642)*
    c. Any concerns regarding any inappropriate statements made or behaviors by the parent/caretakers and/or their level of knowledge regarding the circumstances resulting in child's need for medical care and/or why a physical injury exists, and if so assuring those concerns are documented. *(PR 110.03: Child Maltreatment Clinical Practice Guidelines: Evaluation and Management of Suspected Child Abuse or Neglect: Section III, Child Neglect :Part C Evaluation and Treatment (10). 002647*
    d. It is unsafe for the juvenile to return to or be discharged to his or her parent, guardian or caretaker. *(P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: Procedure (B) 0002636)*
    e. The child lives in an injurious environment, or a home where another child has died or been subjected to abuse, or where an abusive parent or caretaker lives. *(P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: Neglected Juvenile (1) (D) and (2) 0002636)*

    Required actions include:

    f. Assuring the child is not discharged after medical clearance has occurred, until :
        i. Disposition by LCH social workers and DSS has been determined
        ii. A safety plan has been placed on the patients chart. *(P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: Procedure(A) (9) (0002638)*

g. If it is potentially unsafe for the child to return to his parents or caregivers:
   i. First contacting DSS to determine if DSS will assume emergency custody and authorize LCH to retain physical custody of the child; ....and if not.
   ii. Exercising or invoking the authority under the standing Judicial Court Administrative Order granted to LCH under N.C.G.S., Sec. 7B-308, to retain custody of any child **suspected** of abuse. (*P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: Attachment C (0002654)*

Items (1) and (2) listed above were accomplished with the following results.

1. DSS in South Carolina was notified and promptly sent representatives to meet with the parents/caretakers at LCH on Dec 6th, (*DEF PROD 00163*); and to the home to better evaluate the caregivers and the environment. Unfortunately it appears that the DSS visit to the home on Dec 7th was unsuccessful because it occurred while Owen was still hospitalized and the parents remained with him at LCH. *(DEF PROD 00164)*
2. The Child Maltreatment Physician and Clinical Team members at LCH were unable to identify medical or clinical findings sufficient to convert a suspicion of child abuse into a medically substantiated case of child abuse. *(Many references to this conclusion ... DEF PROD 00165)* LCH staff initially followed upon policy requirements that any child age 0-6 months be treated as a suspected child abuse victim, and acted upon clear suspicions of abuse by placing a sitter Owen's room to assure parental supervision immediately following admission.
   Number (3) listed above is where the preponderance of errors and violations of LCH policy occurred. However, certain assumptions or uncertainties presented in LCH records and testimony by LCH staff must first be addressed. Although treated as such in LCH testimony, medical clearance is not synonymous with "ready for discharge" and cannot be treated as such under LCH policy. The assessment of the circumstances under which the injury occurred; parent/caregiver capacity; home environment; the potential need for supervision or parental education; custody at discharge; and development of a safety plan are not medical matters. All of these requirements must still be met even if medical clearance is obtained, and policy requires they be addressed prior to discharge. *(See 3. (a-e) above).* The purpose of these requirements are to assure no child suspected of abuse is discharged into any circumstance where abuse might continue of be perpetuated.

<u>Suspicion of Child Abuse Supposedly Not Confirmed</u>

Laura Newmark asserts, in contradiction to the Child Abuse and Neglect Algorithm (CANA) (*P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: CANA, Attachment F (0002658,)* that "the suspicion was not confirmed, because there had not been a full work up yet". *(Deposition Laura Newmark, MSW, LCH pg. 14.)* . This assertion is noteworthy because it appears to be offered to justify not having taken further action to protect Owen. This conclusion is not supported by LCH policy, actions taken by LCH staff, the facts of this case or common definition. Suspicion was established by policy and acted upon.

- LCH Policy and Procedure specifies that any child age 0-6 months with **any** injury be designated as "**suspicious** for child abuse". *(PR 110.03: Child Maltreatment Clinical Practice Guidelines: Evaluation and Management of Suspected Child Abuse or Neglect: Section I, Child Physical Abuse, Part A. Identification (1).002642)* Owen C[redacted] clearly met this definition.

ANALYSIS (cont.)

- According to the Child Abuse and Neglect Algorithm, contact and consultation of the Clinical Care Management Social Worker (MSW) is triggered by suspicion of abuse by the medical staff. The contact and involvement of MSW, their subsequent notice to DSS, and initiation of the SCAN form triggered by policy supports a suspicion of child abuse was broadly shared by all staff. *(P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: CANA, Attachment F (0002658,)*

- LCH placed a sitter with Owen immediately following admission. "Sitter in room until cleared by DSS/Child Maltreatment Team" Sarah Gall 12/5/09, 1:50 PM. *(CMC (12.05.09) 0065.)* "Hospital has a sitter; parents are having supervised contact with baby" *(DEF PROD 001356)*; and the assignment of a Child Maltreatment Coordinator, Lynn Myers, R.N. (?), represent actions taken to protect Owen confirming a suspicion of abuse by the parents.

- Perhaps purely semantics but a "confirmed suspicion" is typically considered a fact.

The preceding clearly indicates LCH suspected abuse and acted in a manner demonstrating a need to protect Owen from his parents during his hospital stay.

It appears that the hospital seems to be relying on medical substantiation of documented abuse to categorize its actions or inactions as reasonable. This is not correct. Medical substantiation is but one element to be factored into the final decision of whether to discharge or not. In this case, LCH staff clearly failed to exercise their authority to seek protective custody by DSS, or assume involuntary custody under judicial powers granted by statue and court order to retain custody and defer discharge.

Role of the MSW at LCH in Suspected Child Abuse Cases

In deposition Laura Newmark, MSW., describes her role as "serving as liaison between the LCH medical team and DSS", and "sharing information on the clinical status and what is going on with the patient with DSS". Ms. Newmark concludes the final decision regarding Owens discharge and, getting the discharge plan right, is the sole province of DSS. *(Deposition Laura Newmark, MSW, LCH pgs. 10-12)* These conclusions are not supported by LCH policy or the facts of this case.

LCH policy describes the MSW role in suspected child abuse cases as one of active consultation providing aid and assistance in the assessment process, *(P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: Procedure (A) (2), 002637, and Attachment F (0002658).* Specific MSW duties ascribed by policy include: assuring assignment of a Child Maltreatment Coordinator to cases of suspected child abuse; determining disposition of a child suspected of abuse before discharge with DSS, and assuring the safety plan has been placed on the chart in writing prior to discharge. *(P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: Procedure (A) (9) (0002638).* Owen was discharged with no safety plan on the chart, and without a consensus decision by MSW and DSS on discharge disposition, after medical clearance, as required.

FINDINGS and CONCLUSIONS

The MSW has primary responsibility, and was the best or only party in a position to assess items 3 (b, c, f (ii) and g (i)) above, and shares responsibility for 3 (a, d, f (i) and g (ii)) above. By not carrying out these

duties, or assuring they were performed, MSW violated the standard of care and abrogated their duties to protect Owen. The only items listed above which might be considered the exclusive or sole province of DSS are 3(e), review of the home and prior history of child abuse, and authorship of the safety plan in f (ii). I see no liability on the part of the LCH medical staff having relied on the MSW to determine disposition at discharge, seek a safety plan, and having noting in the record that Owen should be discharged with supervision. (See B below). Although supervised and protected from the parents during his hospital stay, Owen was discharged into the parents care without supervision. Those most acquainted with Owens injuries, LCH staff and medical team findings and suspicions, the parents and caregivers demeanor during his stay from Dec. 5-8, 2009 were the MSW staff at LCH.

ADDITIONAL FACTORS

In addition, the MSW was aware, or should have been aware, of several facts and events relevant to child abuse which may have proven critical to DSS. It is not apparent that these facts or events were conveyed to DSS.

A. A member of the LCH nursing staff (RN Sara), conveyed information to MSW regarding a **"private"** conversation with the maternal grandmother. The conversation disclosed the Owen had sustained a previous bruise to the head in November while in the care of his father and uncle that could not be explained. *(CMC 12.05.09, 0096)*

B. The consulting LCH Neurosurgeon, Dr. McClanahan charted that Owen should only be discharged **under supervision**, in a medical record entry at 6:45 pm on 12/7/2009 the night before Owen was discharged. *(CMC 12.05.09 0039)*. It appears from this entry a member of the medical team felt it necessary to assure Owen was not discharged to the singular care of his 19 and 18 year old parents without supervision. The MSW was responsible for conveying this information to DSS and assuring it was in the discharge safety plan. It is not clear this specific medical direction regarding supervision was conveyed or acted upon by MSW.

C. The Maltreatment Clinical Coordinator, Lynne Myers, R.N., charted the safety plan from DSS had **not** been received at 10:32 am on 12/8/2009. Despite the requirement that this plan be on the chart **before** discharge, Owen was discharged to his parents at 12:43 that afternoon. *(Nursing Misc. Inpatient Documentation: Exhibit 31, 000155)* As previously established it was the responsibility of the MSW to assure the safety plan was on Owens chart **prior** to discharge.

D. Both the maternal grandmother Charlotte Williams and Rev. Larry Williams the maternal step-grandfather testified that a Neurologist "Dr. Bailey", assigned to Owen at LCH clearly indicated that Owen was possibly or likely a victim of "shaken baby" child abuse through verbal and graphic physical communication . (Deposition Charlotte Williams, pg. 133, and Deposition of Rev. Larry Williams, pgs. 39-40). As the party responsible for conveying findings and assessments by the medical team at LCH to DSS, Ms. Newmark should have consulted or obtained findings from the attending neurologist and conveyed those finding to DSS. There is no evidence that this medical suspicion or concern was captured on the chart or conveyed to DSS.

Answers filed by SCDSS on January 9, 2012 and February 6, 2012 state that LCH conveyed information to DSS without mentioning a suspect, and that medical findings of abuse were inconclusive, and there were "no concerns of non-accidental trauma". DSS asserts that it received insufficient information from LCH to understand the depth and existence of observations and information which would be needed to

retain custody of Owen. If there was a failure to assess and communicate all medical findings from physician staff, and/or psychosocial observations or concerns to DSS or among LCH staff, Joint Commission Standards PI 5.10, 5.50, and 5.60. In regards to coordination of care and timeliness of sharing relevant patient information may also have been violated.

Finally, the defendant asserts in a motion of summary judgment that, "the decision regarding the discharge of a child into the custody of his parents ...is not a decision which can be made by a hospital or physician". This assertion is not true. (*P.R. 110.03: Juveniles Suspected of Being Abused or Neglected: Attachment C, Exhibit 7, (0002654)* indicates that even if DSS decides to grant the discharge of a child back to the custody of a parent, the Hospital is authorized to retain custody of any child suspected of abuse under a standing Judicial Administrative Order and NCGS 78-308, and convey that decision to DSS and the parents regardless of agreement or consensus.

The decision to either retain custody of the child by LHS or ensure the child is put into some type of emergency custody ensures a proper investigation is done by DSS since it requires court action before placement back to the family. This would seemingly ensure a safe placement for the child since he has been in the custody of his paternal grandparents for years and there has not been any type of indication of trauma since that time.

OUTCOME

By discharging Owen back into the custody of his parents, after all standards of suspected abuse were established under LCH policy and by the actions of LCH staff, LCH violated both its duty to Owen and the standard of care. In doing so LCH failed to take actions which would or could have averted subject exposure to and possibilities for ongoing child abuse. Owens subsequent readmission less than 6 weeks later and the devastating injuries he has now sustained by virtue of child abuse are present day facts which all policies violated by LCH outlined above are designed to prevent. It is my opinion that the negligent actions or failure to act in contravention of clear suspicions of abuse and policy requirements caused and/or contributed to the injuries of Owen Carduff in January 2010.

I wish to reserve the right to modify, correct or amend any findings listed above upon receipt of further information, facts discovered or documents not yet reviewed related to this case.

J. KEVIN MOORE

Sworn to and signed before me
this 3 day of April, 2013

Ashley F. Wilson
Notary Public

My Commission expires: April 29 2017

ASHLEY F. WILSON NOTARY PUBLIC WAKE COUNTY, NC Comm. Exp. April 29 2017

Index for Moore Exhibits

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2. Joint Commission Hospital Accreditation Standards 2006
3. Juveniles Suspected of being Abused or Neglected PR 110.03
4. DSS DEF PROD 00163
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6. DSS DEF PROD 00165
7. Laura Newmark, MSW deposition 14:1-5
8. CMC (12.05.09) 0065
9. DSS DEF PROD 001356
10. Laura Newmark, MSW deposition 10-12
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13. Misc Inpatient Documentation 000155
14. Charlotte Williams deposition 133:13-18
15. Rev. Larry Williams deposition 39-40

J. KEVIN MOORE, M.H.A., J.D.

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EXECUTIVE SUMMARY

Health care executive with 25 years experience managing university teaching and research hospitals and clinics, including Duke Univ., Univ. Of Minn., and Carolinas Health Care System. Consultant advising medical device, pharmaceutical and other health care companies on business models and strategic initiatives, while serving as faculty in medical/legal disciplines. Strong practical and academic experience with M.H.A. and J.D. providing experience and skills for management of complex medical, business and legal issues within a cross-functional environment. Served as Director of Guidant Corporation, on Compliance and Audit Committees, a medical and cardiovascular device company, for 11 years until its acquisition by Boston Scientific.

PROFESSIONAL & BUSINESS EXPERIENCE

- **HHM Consulting Group: President. Raleigh, North Carolina. 2005 – Present**

  Healthcare consultant and management adviser to academic medical centers, physician practices, health systems, medical clinics and hospitals; medical device and pharmaceutical companies; law firms and medical justice services. Experience includes negotiation and authorship of purchase contracts and agreements; construction and interpretation of medical staff bylaws, hospital policies and procedures, regulatory and accreditation requirements and professional compliance; negotiation of contracts for physician services and concierge medicine; evaluation of clinic system and patient flow, assessment of malpractice /legal risk; and review and evaluation of continuing medical and legal education. Clients include: start-ups, law firms, health care insurance companies, health systems, start-ups, international health travel companies, and the Institute for Public Health at UNC. Served as contract COO to American Housecall Physicians, Inc. 2006- 2007. Currently teaching health law and ethics requirements for N.C. Board of Examiners licensure in Long Term Care.

- **Arbor Group LLC: Vice President. Carrboro, North Carolina. 2003 – 2005**

  Consulting and strategic planning to biotech and pharmaceutical start-ups, executive medicine companies, governmental and private partnerships. Licensing and acquisition opportunity evaluation; due diligence; interim management; university and government relations; and venture capital solicitations and fundraising strategies. Prepared health care agenda for North Carolina Institute for Emerging Issues Health Care Leadership Forum 2005. Corporate Audit Committee Preceptor, National Association of Corporate Directors.

- **Advanced Medical Productions: Vice President for Strategic Planning and Business Development. Chapel Hill, North Carolina. 2001 – 2003.**

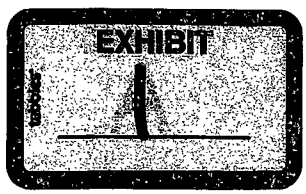
  Served as Senior Business Development officer in this media development company specializing in medical education, healthcare documentaries and educational programs with national broadcasts on Discovery Channel, The Learning Channel and Discovery Health. Broadcast programs include "The Operation" and "Hospital."

- **Carolinas Medical Center: Senior Vice President and Chief Operating Officer. Charlotte, North Carolina. 1997 – 2001**

  Chief Operating Officer and Senior Administrator for Carolinas Medical Center (CMC), the 777-bed level one trauma center, teaching and referral hospital in Carolinas Health Care System. Direct reports included 8 VPs and administrators including OR, Pharmacy, Emergency Department, Nursing Services, Heart Center, Anesthesiology, Neurosurgery, Clinical Labs and Pathology. Total scope of operations included more than 5,000 employees and four facilities. Selected accomplishments include: consolidation of formulary and pharmacy administration at 4 hospitals in Charlotte; CMC 2000 JCAHO accreditation awarded with distinction; centralized dietary services in 7 hospitals in private joint venture achieving $1.9 MM savings in year 1; exceeded financial targets and goals in 4 successive years with increases in clinical volumes, reimbursement margins and market share.

- **Guidant Corporation: Board of Directors. Indianapolis, Indiana. 1995- 2006**

  Served as Director for Guidant Corporation for 11 years including member of Audit, Finance and Compliance Committees for this Fortune 500 medical and cardiovascular device company. Acquired by Boston Scientific in 2006 for over $27 billion. Review and understanding of new technology, emerging companies, supply chain requisites, reimbursement strategies, patent and IP protection and competitive medical solutions in medical device industry required.



- **Duke University Medical Center (DUMC). Durham, North Carolina. 1984 – 1997**

  Associate Chief Operating Officer, Duke Hospital, 1993 – 1997, responsible for Departments and Services, including Pharmacy, Radiology, Life Flight Air Ambulance, Emergency Department, Clinical Laboratories, Community and Family Medicine, at this 890-bed teaching and referral hospital. Responsible for design, construction and operations of Duke Ambulatory Surgery Center.

  Assistant Director, 1990-1993 Surgical Private Diagnostic Clinic with over 300 physicians and 500,000 annual visits.;

  Director Management Services, 1984-1990 for Medical Center Administration, responsible for Risk Management, Grants and Contracts, Research and Laboratory Administration, Environmental Safety, Malpractice Claims Analysis and Hyperbaric Medicine.

- **Robbins, Zelle, Larson & Kaplan Law Firm: Associate/Law Clerk. Minneapolis, Minnesota. 1983 – 1984**

  Performed legal research and case analysis for corporate clients for this 400-person law firm with 8 US and 3 international offices, specializing in insurance subrogation defense, corporate law, personal injury claims, and trusts and estates.

- **University of Minnesota Hospitals and Clinics: Assistant Director. Minneapolis, Minnesota. 1980 – 1983**

  Responsible for 300 bed inpatient med/surg units and ancillary operations in this 720-bed teaching hospital. Chief Planning Officer for new inpatient replacement facility. Recruited to competitive fellowship in premier teaching and research health system in the birthplace of Managed Care Organizations.

EDUCATION

- University of Minnesota, School of Law, Minneapolis, MN. Juris Doctor (J.D.), 1984.
- Duke University, Graduate School of Health Administration, Durham, NC. Masters of Health Administration (M.H.A.), 1979.
- Duke University, Trinity College of Arts and Sciences, Durham, NC. Bachelor of Science (B.S.), 1976.

TEACHING

- **University of North Carolina School of Public Health: Clinical Lecturer. Chapel Hill, North Carolina. 2002 – 2006.**

  Lecturer on legal and ethical issues in Long Term Care, medical products, patent protection, technology procurement and applications, conflict of interest rules and prohibited transactions in hospital/physician relations. Specific focus on Federal rules and regulations, reimbursement approval, and Group Purchasing Organizations (GPOs). Graduate students learn hospital operations, governing rules and regulations, and ethical issues facing health care in today's competitive market and heavily regulated environment.

- **Wake Forest School of Law, Continuing Legal Education: Lecturer. Winston-Salem, North Carolina. 1998 – 2002.**

  Lecturer, panelist and speaker on end-of-life and patient care issues including advanced directives, living wills, "do not resuscitate" orders, right to refuse treatment orders, AMA discharges, confidentiality and durable power of attorney.

- **Graduate School of Health Administration/Fuqua School of Business, Duke University: Adjunct Associate Professor. Durham, North Carolina. 1990 – 1998.**

  Chief lecturer on health law, risk management, federal healthcare regulation and reimbursement. State Certificate of Need Laws, Health Planning Agencies, applications for new or expanded clinical service programs. Hospital policies, procedures and accreditation.

- **North Central Legal Assistance Program: Volunteer Attorney. Durham, North Carolina. 1989 – 1998.**

  Pro bono attorney and senior counsel to Durham and Person County, a publicly funded legal assistance program. Senior Counsel before the North Carolina State Supreme Court on behalf of NC Legal Services clients in Stachlowski v. Stach, NC Sup Ct (1991).

PROFESSIONAL ACTIVITIES AND PUBLIC SERVICE

- National Association of Corporate Directors: Member, 2004 – Present.
- Panelist on Audit and Governance (May 2005) Speaker on Mergers and Acquisitions (Oct 2006).
- Society for Innovative Medical Practice Design. 2006 to 2009.
- Public School Foundation Board, Chapel Hill-Carrboro City Schools. 2004 – Present.
- Duke University Nasher Museum of Art, Board of Directors. 2004 – 2009.
- Guidant Corporation, Board of Directors: Audit, Finance and Compliance Committees. 1995 – 2006.
- Duke University, Fuqua School, Global Capital Markets, Directors Institute. 2004.
- Harvard School of Public Health, Graduate: Hospital Trustees Certification Program. 1980
- Arts and Science Council of Charlotte, NC: Board of Directors, Executive Committee. 1997 – 2000.
- American Red Cross, Charlotte, NC and Durham, NC: Board of Directors. 1987 – 1999.
- MEDIC, Mecklenburg County Emergency Medical Services, Charlotte, NC: Board of Directors. 1997 – 2000.
- Durham Arts Council, Durham, NC: Chairman of the Board, Finance Committee, Director. 1989 – 1997.
- North Central Legal Aid Program, Durham, NC: Volunteer Attorney and Senior Counsel. 1989 – 1997.
- Duke University, Durham, NC: Board of Trustees : 1976 – 1980.
- North Carolina Bar Association: Member. 1985 – Present.

PROFESSIONAL MEMBERSHIPS (Past and Present)

- American Hospital Association
- American College of Health Care Executives
- American Academy of Hospital Attorneys
- North Carolina Bar Association
- Medical Group Managers Association
- American Bar Association: Health Law Section
- National Association of Corporate Directors

EXHIBIT

"2"

Joint Commission
on Accreditation of Healthcare Organizations
Setting the Standard for Quality in Health Care

Hospital Accreditation Standards

2006 HAS

Accreditation Policies

Standards

Elements of Performance

Scoring

Standard PC.2.150

Patients are reassessed* as needed.

Rationale for PC.2.150

Each patient may be reassessed for many reasons including the following:

- To evaluate his or her response to care, treatment, and services
- To respond to a significant change in status and/or diagnosis or condition
- To satisfy legal or regulatory requirements
- To meet time intervals specified by the hospital
- To meet time intervals determined by the course of the care, treatment, and services for the patient

Element of Performance for PC.2.150

C M 1. Each patient is reassessed as needed.

Additional Standard for Victims of Abuse

Standard PC.3.10

Patients who may be victims of abuse or neglect are assessed. (*See* standard RI.2.150.)

PC

Rationale for PC.3.10

Victims of abuse or neglect may come to a hospital in a variety of ways. The patient may be unable or may be reluctant to speak of the abuse, and it may not be obvious to the casual observer. Staff needs to be able to identify abuse or neglect as well as the extent and circumstances of the abuse or neglect to give the patient appropriate care.

Criteria for identifying and assessing victims of abuse, neglect, or exploitation should be used throughout the hospital. The assessment of the patient must be conducted within the context of the requirements of the law to preserve evidentiary materials and support future legal actions.

Elements of Performance for PC.3.10

A 1. The hospital develops or adopts criteria† for identifying victims in each of the following situations:
   - Physical assault
   - Rape
   - Sexual molestation
   - Domestic abuse
   - Elder neglect or abuse
   - Child neglect or abuse

* The scope and intensity of any further assessments are based on the patient's diagnosis; the setting; the patient's desire for care, treatment, and services; and the patient's response to any previous care, treatment, and services.

† The Family Violence Prevention Fund is one resource that can be contacted for further information at http://www.fvpf.org.

B 2. Appropriate staff* is educated about abuse or neglect and how to refer as appropriate.

A 3. A list of private and public community agencies that provide or arrange for assessment and care of abuse victims is maintained to facilitate appropriate referrals.

B 4. Victims of abuse or neglect are identified using the criteria developed or adopted by the hospital at entry into the system and on an ongoing basis.

B 5. The hospital's staff refers appropriately or conducts the assessment of victims of abuse or neglect.

A 6. All cases of possible abuse or neglect are reported to appropriate agencies according to hospital policy and law and regulation.

A 7. All cases of possible abuse or neglect are immediately reported in the hospital.

PC

Standards PC.3.20 Through PC.3.110

Not applicable

Additional Standard for Patients Being Treated for Addictions

Obtaining and interpreting information about substance abuse, dependence, or other addictive behaviors is necessary to develop treatment plans. By gathering the data and information on the items listed in the standards, the clinician can assess the relationship of the physical state of each patient to the dependence; assess the nature of the patient's compulsion to use alcohol, drugs, or other addictive behaviors; assess the intensity of the patient's mental preoccupation with alcohol, drugs, or other addictive behaviors such as gambling; and distinguish between alcohol-related symptoms, drug-related symptoms, and symptoms of other addictive behaviors and other preexisting physical problems or pathologic behaviors.

Standard PC.3.120

The needs of patients receiving psychosocial services to treat alcoholism or other substance use disorders are assessed.

Elements of Performance for PC.3.120

A 1. The content of the assessment and reassessment of patients receiving psychosocial services to treat alcoholism includes at least the following:
- The patient's history of alcohol, nicotine, and other drug use, including age of onset, duration, intensity, patterns of use (for example, loss of control over amounts or frequencies of consumption, inability to consistently abstain from use, relapse), and consequences of use

* Staff should be able to screen for abuse and neglect as indicated by the patient's needs or conditions. The organization may define who conducts the full assessment for alleged or suspected abuse or neglect or refer to another organization.

Diagnostic Services

Standard PC.3.230

Diagnostic testing* necessary for determining the patient's health care needs is performed.

Elements of Performance for PC.3.230

C M 1. Diagnostic testing and procedures are performed as ordered.

C M 2. Diagnostic testing and procedures are performed in a timely manner as defined by the hospital.

C M 3. When a test report requires clinical interpretation, relevant information is provided with the request.

Planning Care, Treatment, and Services

Planning includes creating an initial plan for care, treatment, and services appropriate to the patient's specific assessed needs, and then revising or maintaining the plan based on the patient's response. Planning for care, treatment, and services is individualized to meet the patient's unique needs and circumstances. Performed by qualified individuals, planning for care, treatment, and services involves using an interdisciplinary approach when warranted and involving the patient to the extent possible.

The plan may be modified or terminated based on reassessment; the patient's need for further care, treatment, and services; or the achievement of plan of care goals. This modification may result in planning for the patient's transfer to another setting or service or discharge from the hospital.

Standard PC.4.10

Development of a plan for care, treatment, and services is individualized and appropriate to the patient's needs, strengths, limitations, and goals.

Rationale for PC.4.10

Planning care, treatment, and services is not limited to developing a written plan. Rather, planning is a dynamic process that addresses the execution of care, treatment, and services. The plan for care, treatment, and services must be consistently re-evaluated to ensure that the patient's needs are met. Planning for care, treatment, and services includes the following:

- Integrating assessment findings in the care-planning process

* Diagnostic testing includes laboratory, radiologic, electrodiagnostic, and other functional tests and imaging technologies.

- Developing a plan for care, treatment, and services that includes patient care goals that are reasonable and measurable
- Regularly reviewing and revising the plan for care, treatment, and services
- Determining how the planned care, treatment, and services will be provided
- Documenting the plan for care, treatment, and services
- Monitoring the effectiveness of care planning and the provision of care, treatment, and services
- Involving patients and/or families in care planning

Elements of Performance for PC.4.10

B 1. Care, treatment, and services are planned to ensure that they are individualized to the patient's needs.

B 2. Development of a plan for care, treatment, and services is based on the data from assessments.

3. Not applicable

4. Not applicable

5. Not applicable

B 6. Patient needs, goals, time frames, settings, and services required to meet the patient needs and/or goals determine the plan for care, treatment, and services.

7. Through 11. Not applicable

C Ⓜ 12. Evaluation of the patient is based on the patient care goals and the patient's plan for care, treatment, and services.

C Ⓜ 13. The goals of care, treatment, and services are revised when necessary.

B 14. Plans for care, treatment, and services are revised when necessary.

15. Not applicable

16. Not applicable

B 17. The plan for care, treatment, and services considers strategies to limit the use of restraints or seclusion as appropriate.

Providing Care, Treatment, and Services

Caring for patients involves providing individualized, planned, and appropriate interventions in settings responsive to specific individual needs. "Care" includes care, treatment, services, rehabilitation, habilitation, or another intervention provided to the patient by the hospital.

The goal of providing effective care, treatment, and services is met when the following are performed well:

- Intervening in a collaborative manner (in light of assessed patient needs)
- Educating the patient
- Promoting health and providing appropriate preventive care
- Providing supportive care, treating a disease or condition, and/or treating symptoms (such as pain, nausea, or dyspnea) using accepted professional standards of practice
- Meeting the patient's nourishment needs, if appropriate to the setting
- Helping patients with appropriate restorative services, including assistance with activities of daily living, such as eating, dressing, grooming, bathing, oral hygiene, ambulation, and toilet activities
- Rehabilitating physical, communicative, or psychosocial impairment or maintaining the patient's level of functioning
- Coordinating the care, treatment, and services provided to a patient
- Optimizing comfort and dignity during end-of-life care
- Involving families as indicated and acceptable to the patient

All interventions should respect and encourage the patient's ability to make choices, to develop and maintain a sense of achievement about attaining their personal health goals, and to choose to continue or modify participation in the care process.

The activities comprising care, treatment, and services may be performed by a variety of staff whose roles and responsibilities are determined by the component of care, treatment, and service being provided; relevant licensure; law and regulation; registration; certification; scope of practice; job description; or privileges.

Standard PC.5.10

The hospital provides care, treatment, and services for each patient according to the plan for care, treatment, and services.

Elements of Performance for PC.5.10

A M 1. The hospital provides care, treatment, and services for each patient according to the plan for care, treatment, and services.

2. Not applicable

3. Not applicable

4. Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

   Note: *The preceding requirement is not scored here. It is scored at National Patient Safety Goal 1, Requirement 1A.*

Standard PC.5.20

Not applicable

Standard PC.5.30
Not applicable

Standard PC.5.40
Not applicable

Standard PC.5.50
Care, treatment, and services are provided in an interdisciplinary, collaborative manner.

Rationale for PC.5.50
A collaborative, interdisciplinary approach to meeting the patient's needs and goals helps to coordinate care, treatment, and services and achieve optimal outcomes. The mix of disciplines involved and the intensity of the collaboration will vary as appropriate to each patient and the scope of services provided by the hospital (*see* standards MS.2.10 and MS.2.20). An interdisciplinary approach should not be interpreted as a requirement for an interdisciplinary care plan or the signing of other individual's notes. While an interdisciplinary care plan may be one method of accomplishing this goal, it is not required.

PC

Element of Performance for PC.5.50
B 1. Care, treatment, and services are provided in an interdisciplinary, collaborative manner as appropriate to the needs of the patient and the hospital's scope of services.

Standard PC.5.60
The hospital coordinates the care, treatment, and services provided to a patient as part of the plan for care, treatment, and services and consistent with the hospital's scope of care, treatment, and services.

Rationale for PC.5.60
Throughout the provision of care, treatment, and services, patients should be matched with appropriate internal and external resources to meet their ongoing needs in a timely manner. Care, treatment, and services should be coordinated between providers and between settings, independent of whether they are provided directly or through written agreement.

Elements of Performance for PC.5.60
B 1. The hospital coordinates the care, treatment, and services provided through internal resources to a patient.

B 2. When external resources are needed, the hospital participates in coordinating care, treatment, and services with these resources.

B 3. The hospital has a process to receive or share relevant patient information to facilitate appropriate coordination and continuity when patients are referred to other care, treatment, and service providers.

B 4. There is a process to resolve duplication or conflict with either internal or external resources.

B 5. The activities detailed in the plan of care, treatment, and services is designed to occur in a time frame that meets the patient's health needs.

Education

Standard PC.6.10

The patient receives education and training specific to the patient's needs and as appropriate to the care, treatment, and services provided.

PC

Rationale for PC.6.10

Patients must be given sufficient information to make decisions and to take responsibility for self-management activities related to their needs. Patients and, as appropriate, their families are educated to improve individual outcomes by promoting healthy behavior and appropriately involving patients in their care, treatment, and service decisions.

Elements of Performance for PC.6.10

B 1. Education provided is appropriate to the patient's needs.

C M 2. The assessment of learning needs addresses cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication as appropriate.

B 3. As appropriate to the patient's condition and assessed needs and the hospital's scope of services, the patient is educated about the following:
- The plan for care, treatment, and services
- Basic health practices and safety
- The safe and effective use of medications
- Nutrition interventions, modified diets, or oral health
- Safe and effective use of medical equipment or supplies when provided by the hospital
- Understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
- Habilitation or rehabilitation techniques to help them reach the maximum independence possible

EXHIBIT

"3"

CAROLINAS HEALTHCARE SYSTEM

Category: Patient Rights
Policy: Abuse
Number: PR 110.03
Date of Issue: 08/91 Reviewed / Revised: 05/11

JUVENILES SUSPECTED OF BEING ABUSED OR NEGLECTED

SUMMARY STATEMENT

This policy statement relates to the issue of awareness, detections and management of children at risk for abuse or neglect in the inpatient, physician office, and urgent care settings. It provides guidance on the procedure that should be followed in cases of suspected abuse or neglect.

DEFINITIONS

A. **Juvenile**

Any person under 18 years of age who is not emancipated by marriage or court order, or a member of the armed forces.

B. **Abused Juvenile**

1. A juvenile whose parent, guardian, custodian or caretaker

a. inflicts or allows to be inflicted serious physical injury, which causes or creates a substantial risk of injury, death, disfigurement, impairment of physical health or loss or impairment of a function of any bodily organ;

b. uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior;

c. creates or allows serious emotional damage;

d. commits or permits illegal sexual activity with or by the juvenile; or

e. encourages or approves the juvenile's commission of delinquent acts.

C. **Neglected Juvenile**

1. A juvenile who:

a. is receiving improper care, supervision, or discipline;

b. has been abandoned; (See abandoned infant/child policy)

c. is not provided necessary medical or remedial care;

d. lives in an injurious environment or has been placed illegally in care or for adoption.

2. A special needs infant who:

   a. is being denied appropriate nutrition, hydration, or medication; or

   b. has medically indicated treatment withheld unless, in the treating physician's judgement, one of several conditions is met.

It is relevant to consider whether the juvenile lives in a home where another juvenile has died as a result of abuse or neglect or in a home where another juvenile has been subjected to physical abuse by an adult who regularly lives in the home.

D. **Dependent Juvenile**

1. A juvenile who:

   a. is in need of assistance or placement because there is no parent, guardian or custodian responsible for the juvenile's care or supervision; or

   b. has a parent, guardian, or custodian, due to physical or mental incapacity and in the absence of an appropriate alternative child care arrangement, who is unable to provide for care or supervision.

E. **Caretaker**

1. Any person other than a parent, guardian or custodian, or adult member of the juvenile's home, who has care of a juvenile, including any blood relative, stepparent, foster parent, or house parent, cottage parent, or other person supervising a juvenile in a residential child care facility; or

2. Any adult person with the approval of the care provider in a day care facility.

PROCEDURE

A.

1. Clinical team identifies child in whom abuse or neglect is suspected and initiates suspected child maltreatment inpatient order set followed by discharge order set if applicable.

2. Consult CHS Clinical Care Management Social Worker to aid in the assessment process.

   CPN/Urgent Cares: page 704-355-4088 pager 1436.

   CHS Hospitals: utilize your hospital MSWs during regular business hours (8:00am - 4:30pm) and page 704-355-4088 pager 1436 for after hour concerns. Refer to NC Statute 90-21.20 (b) for indications for law enforcement involvement (Attachment A).

3. Complete CHS Suspected Child Abuse and Neglect (SCAN) form available on Care

Line. Use SCAN admission and discharge order forms for admission to LCH.

4. Document all positive exam findings on SCAN form including completion of diagrams. If evidentiary photography is requested by outside agency they are responsible for securing such photography and maintaining chain of custody. Contact SCAN on call team or Child Maltreatment Coordinator for assistance with photography documentation needed for child's medical management.

5. All cases of suspected abuse or neglect should be reported to the Department of Social Services (DSS) in the County where the child resides. The call to DSS may be initiated by the staff member identifying the abuse/neglect, the medical social worker or any other member of the healthcare team involved in the case. Have readily available as much of the following information as possible:

   - the facts of the case
   - the child's and parents' home address, telephone numbers, dates of birth and social security numbers
   - siblings names, ages and whereabouts

6. If the parent, guardian, custodian or caretaker refuses to authorize necessary medical treatment for the juvenile, refer to administrative policy *PR 120.06 Consent for Treatment.*

7. Consider consult to CMC Pediatrics (CHIPS Team; Children's Hospital Inpatient Service) for assistance with medical management. For patients with evidence of acute, multi-system injury consult CMC Trauma Service.

8. Refer to Child Maltreatment Clinical Practice Guidelines to assist with medical management. (Attachment B, B1-3)

9. **When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS and the safety plan has been placed on the chart in writing, if applicable.**

B. When a physician determines that a juvenile should remain in the hospital for medical reasons, or that it is unsafe for the juvenile to return to his or her parent, guardian, or caretaker, the physician or administrator should first contact the director of the Department of Social Services (or representative on call) to determine if the Department of Social Services will take emergency custody and authorize the hospital to retain physical custody of the juvenile.

   In the event the Department of Social Services is unwilling to take custody or cannot be contacted, the local District Court has authorized the physician or administrator to retain physical custody of the juvenile whenever the physician determines that (1) the juvenile should remain for medical treatment or (2) according to his or her medical evaluation, it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker. (See *Administrative Order, Attachment C)*

To retain physical custody under court order, the physician who examines the juvenile must certify the applicable circumstances in writing on the *Certification of Necessity for Retention of Custody, Attachment D.* A copy of the written certification must be provided to the juvenile's parent, guardian, custodian, or caretaker and the director of the Department of Social Services. A copy of the completed certification must be placed in the juvenile's medical record.

The Administrative Order allows the hospital to keep physical custody of the juvenile for a period not to exceed twelve hours from the time and date of the written certification. Before the twelve hours expire, either the Department of Social Services must have assumed custody or the Juvenile Court must issue an additional order permitting continued custody beyond twelve hours.

C. Any person making a report of suspected juvenile abuse, neglect, or dependency, or who testifies in a later court proceeding resulting from a report, is immune from civil or criminal liability so long as the person acted in good faith.

D. If it is suspected the juvenile has been the victim of a crime but does not come under the definition of "abused juvenile" or "neglected juvenile", the juvenile's parent, guardian, custodian, or caretaker and/or law enforcement officials should be notified. **If a juvenile seeks treatment for a sexually related assault then reporting is based on the juvenile's consent (NC Statue 90-21.5).** See (Attachment E).

E. Any questions concerning this procedure should be directed to the facility administrator or the Carolinas HealthCare System office of Risk Management.

REFERENCES

See Attachment A: Involvement of Law Enforcement (NC Statute 90-21.20 (b)).
See Attachment B: Child Maltreatment Clinical Practice Guidelines
See Attachment C: Administrative Order Retention of Custody of Juvenile Suspected to be Abused
See Attachment D: Certification of Necessity for Retention of Custody
See Attachment E: Situations in which minors may consent to treatment (NC Statute 90-21.5)
See Attachment F: Child Abuse and Neglect Algorithm

APPROVALS

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	Suzanne Freeman, Senior Vice President, Carolinas HealthCare System
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Attachment A
INVOLVEMENT OF LAW ENFORCEMENT

Article 1C

Physicians and Hospital Reports

§90-21.20. Reporting by physicians and hospitals of wounds, injuries and illnesses.

(a) Such cases of wounds, injuries or illnesses as are enumerated in subsection shall be reported as soon as it becomes practicable before, during or after completion of treatment of a person suffering such wounds, injuries, or illnesses. If such case is treated in a hospital, sanitarium or other medical institution or facility, such report shall be made by the Director, Administrator, or other person designated by the director or Administrator, or if such case is treated elsewhere, such report shall be made by the physician or surgeon treating the case, to the chief of police or the police authorities of the city or town of this State in which the hospital or other institution, or place of treatment is located. If such hospital or other institution or place of treatment is located outside the corporate limits of a city or town, then the report shall be made by the proper person in the manner set forth above the sheriff of the respective county or to the one of his deputies.

(b) Cases of wounds, injuries or illnesses which shall be reported by physicians, and hospitals include every case of a bullet wound, gunshot wound, powder burn or any other injury arising from or caused by, or appearing to arise from or be caused by, the discharge of a gun or firearm, every case of illness apparently caused by poisoning, every case of a wound or injury caused, or apparently caused, by a knife or sharp or pointed instrument if it appears to the physician or surgeon treating the case that a criminal act was involved, and every case of a wound, injury or illness in which there is grave bodily harm or grave illness if it appears to the physician or surgeon treating the case that the wound, injury, or illness resulted from a criminal act of violence.

(c) Each report made pursuant to subsections (a) and (b) above shall state the name of the wounded, ill or injured person, if known, and the age, sex, race, residence or present location, if known, and the character and extent of his injuries.

(c1) In addition to the reporting requirements of subsection (b) of this section, cases involving recurrent illness or serious physical injury to any child under the age of 18 years where the illness or injury appears, in the physician's professional judgment, to be the result of non-accidental trauma shall be reported by the physician as soon as it becomes practicable before, during, or after completion of treatment. If the case is treated in a hospital, sanitarium, or other medical institution or facility, the report shall be made by the Director, Administrator, or other person designated by the Director or Administrator of the medical institution or facility, or if the case is treated elsewhere, the report shall be made by the physician or surgeon treating the case to the chief of police or the police authorities of the city or town in this State in which the hospital or other institution or place of treatment is located. If the hospital

or other institution or place of treatment is located outside the corporate limits of a city or town, then the report shall be made by the proper person in the manner set forth above to the sheriff of the respective county or to one of the sheriff's deputies. This reporting requirement is in addition to the duty set forth in G.S. 7B-301 to report child abuse, neglect, dependence, or the death of any juvenile as the result of maltreatment to the director of the department of social services in the county where the juvenile resides or is found.

(d) Any hospital, sanitarium, or other like institution or Director, Administrator, or other designated person, or physician or surgeon participating in good faith in the making of a report pursuant to this section shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed as the result of the making of such report. (1971, c.4; 1977, c. 31; c. 843, s.2.)

Attachment B
CHILD MALTREATMENT CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines
CHS Inpatient Units and Emergency Department

Evaluation and Management of Suspected Child Abuse or Neglect

I. CHILD PHYSICAL ABUSE

A. Identification

Injuries (bruises, burns, fractures; this list is not inclusive) that should be considered suspicious for physical abuse:

1. Age 0-6 months: Any injury.

2. Age 6 months or older:

   a. Bruises, lacerations, or burns to protected, fleshy, or flexor surfaces— for example, inner thighs, abdomen, neck, face (other than frontal prominence), pinna, and genitalia.
   b. Bruises, lacerations, or burns showing an object pattern—for example, belt loop, cigarette burn, and curling iron.
   c. Full thickness burns, especially scald burns.
   d. Fractures, especially metaphyseal fractures, complex or wide skull fractures, rib fractures, sternal fractures, spinous process fractures or scapula fractures.
   e. Significant head injury, especially subdural hematoma, retinal hemorrhage, subgaleal hematoma, avulsed hair, complex or wide skull fracture. Head injury should be considered whenever a child presents with vomiting or altered consciousness, or bloody spinal fluid is found on lumbar puncture, but an infectious process cannot be readily diagnosed.
   f. Intraabdominal injury, especially rupture or hematoma of internal organ.

3. Age 0-10 years (or older based on clinical evaluation): Positive urine or blood screen for alcohol or drugs of abuse. Injuries that are not consistent with history.

B. Essential Aspects - Caretaker History

1. Does the parent/guardian or child give a logical explanation that is consistent with the age, pattern, and severity of the injury? This should be assessed by clinician familiar with normal pediatric development.

   a. Consider developmental level of child. Is the child capable of the reported action? For example—a 6-month-old cannot unbuckle a car seat.

b. Consider biomechanics of injury. For example--a fall from less than 4 feet rarely causes a fracture and almost never causes intracranial hemorrhage; a child who cannot crawl or walk should not have a bruise, fracture, burn, or laceration.

C. Evaluation & Treatment

1. Refer to CHS policy *PR 110.03* for policies regarding reporting of *Juveniles Suspected of Being Abused or Neglected.*

2. Complete physical examination

3. Complete SCAN form (available on Care Line) and SCAN Admission Order Set.

4. Age 0-2 years: Non-accidental Trauma (NAT) series should be considered in all cases (not long bone series or "babygram"). **Pediatric radiologist to do official reading.**

5. Age 2-4 years: NAT series should be considered (not long bone series or "babygram"). **Pediatric radiologist to do official reading.**

6. Nuclear medicine bone scan (or repeat NAT series in 2 weeks) if index of suspicion for skeletal injury remains high despite negative initial NAT series (for example-- in cases of Abusive Head Trauma (formerly known as "Shaken Baby Syndrome").

7. A screening panel to rule-out bleeding disorder should be considered (refer to SCAN Admission Order set).
   a. CBC with platelets & peripheral smear
   b. PT/PTT
   c. PFA-100 (platelet function assay)
   d. Fibrinogen
   e. Thrombin time

8. Liver enzymes (AST/ALT), amylase, and lipase levels should be considered if abdominal trauma is suspected or present.

9. CT scan of head if suspected acute intracranial injury or other injuries that indicate need to assess for non-accidental injuries; consider MRI scan of head if subacute (older than 5 to 7 days) or chronic intracranial injury after 2-3 days and patient is stable.

10. CT scan of abdomen if suspected blunt thoracoabdominal trauma or abdominal bruising present.

11. Pediatric Ophthalmology consult for thorough fundoscopy in cases of:
    a. Suspected intracranial injury;
    b. Suspected Abusive Head Trauma (metaphyseal fractures, subdural/subarachnoid

hemorrhage, and/or posterior rib fractures).

c. Spiral fracture, metaphyseal fracture, or other injury in child under age 2 suggestive of shaking or twisting injury.
d. Fracture in infant under age 6 months or any other highly specific fracture for abuse under 1 year.

II. CHILD SEXUAL ABUSE

A. Identification

Findings that should be considered suspicious for sexual abuse (this list is not inclusive):

1. Any injury to the genitalia (especially to the hymen or vestibule in girls) or anus.
2. Identification of an STD: Chlamydia, gonorrhea, HSV, HPV, HIV, HBV, HCV, Trichomonas, syphilis.
3. Positive pregnancy test (especially if < 14 y/o).
4. Any history or statement or witnessed incident consistent with sexual abuse.

B. Essential Aspects - Caretaker History

1. Does the parent/guardian or child give a logical explanation that is consistent with the examination findings? For example--in a child under 3 with genital warts, is there a history of maternal HPV infection during pregnancy or delivery?

C. Evaluation & Treatment

1. Refer to CHS policy *PR 110.03 Juveniles Suspected of Being Abused or Neglected* for policies regarding reporting.
2. Complete physical examination
3. Use SCAN form for documentation.
4. Age 0-2 years: skeletal survey in all cases with visible acute injuries.
5. Age 2-4 years: skeletal survey should be considered if visible acute injuries.
6. For non-acute sexual abuse allegations in an otherwise healthy child without continued access to an alleged perpetrator: after reporting to the appropriate investigating agencies, a child may be referred to their primary care provider or Pat's Place Child Advocacy Center in lieu of receiving a detailed sexual abuse examination in the Emergency Department.
7. Careful inspection of external genitalia and anus for evidence of trauma, in exam

setting with adequate lighting, positioning, and magnification. Never force a child to be examined.

a. Position child in a supine frog-leg position; adolescent male in supine position for genitalia and decubitus position for anus exam; adolescent female supine in heelrests (dorsal lithotomy).
b. In girls, use gentle labial traction technique to visualize vestibule and hymen. Also inspect labia majora, perineum, inner thighs, and lower abdomen.
c. In girls, position in the prone knee-chest position to confirm suspected abnormal hymenal or vestibular findings.
d. In boys, careful inspection of penis, scrotum, perineum, inner thighs, lower abdomen.
e. In both sexes, careful inspection of anus and perianal area for evidence of trauma. Use gentle gluteal separation to inspect anal rugae and outer canal.

8. Testing for sexually transmitted infection may be obtained if the history suggests the child had genital/anal/oral contact with the perpetrator's genitalia, there is evidence of genital/anal/oral trauma, or if there is genital/anal discharge:

- Gonorrhea cultures (Thayer Martin media, NOT DNA PROBES) of: throat; vagina (in prepubertal or young teen girls), cervix (in postpubertal girls), or male urethra, and anus.
- May consider use of urine PCR (urine NAAT) testing for Gonorrhea or Chlamydia, but is not considered legal gold standard. Positive urine PCR should be confirmed with culture. Obtain culture if giving prophylaxis in prepubertal patients
- Chlamydia cultures (pink viral culture media, NOT DNA PROBES) of: vagina (in prepubertal or young teen girls), cervix (in postpubertal girls) or male urethra, and anus.
  Note: to cause minimal discomfort while culturing the vagina in prepubertal girls, the examiner should use labial traction technique to identify the hymenal introitus. An assistant should gently insert a mini-tip (urethral-size) Dacron swab moistened with nonbacteriostatic saline or water through the introitus without contacting the hymen, and gently swab the distal vagina.
- Blood should be drawn for syphilis and HIV. Evaluate the patient's hepatitis B immunization status.
- Wet prep of discharge for trichomonas, clue cells, or leukorrhea (>10WBC/HPF).
- Culture of vesicles or ulcers for HSV.
- HIV and RPR should be obtained if indicated by history.

9. If acute sexual assault (penetrating genital injury and/or contact with perpetrator's genitalia within the past 72 hours):

a. A forensic evidence collection kit (SBI rape kit) should be utilized. Contact the relevant law enforcement agency for retrieval of evidence and maintain appropriate chain of custody.

b. Cultures and blood for STD's should generally not be obtained unless there is an additional clinical indication (prior abuse or symptoms).
c. DNA probes may be obtained (see above) as screening. However cultures remain the gold standard.
d. Prophylactic antibiotic therapy against gonorrhea and chlamydia infection should be given if requested by patient or family in case of child sexual assault. Consider prophylaxis against trichinosis and pregnancy. Prophylactic therapy should be administered in cases of adolescent sexual assault. Refer to Centers for Disease Control or American Academy of Pediatrics guidelines for current recommendations. See Attachment # B-1.
e. Prophylactic antiretroviral therapy should be offered to the victim and/or family whenever contact with potentially infectious bodily fluids may have occurred, and must be offered if the alleged perpetrator is known to be at high risk for HIV infection. If the perpetrator is unknown, the decision for therapy should be based on the local HIV epidemiological rate. Consultation with on-call pediatric infectious disease physician and SCAN on call physician is recommended. See Attachments # B-2.
f. Emergency contraception (Plan B) should be offered to all pubertal or postpubertal female victims. See Attachment # B-3.
g. Consult appropriate surgical subspecialist (Gynecology, Pediatric Surgery, or Pediatric Urology) in cases of severe anogenital injury.

10. Whenever possible, arrange medical follow-up according to the following schedule:

a. In 1-2 days with PCP or Pat's Place Child Advocacy Center for further examination and photodocumentation of injuries;
b. In 1 month, 3 months, and 6 months with PCP, or appropriate specialist or caregiver for follow-up examination and testing for STD's, especially HIV.

11. Discuss and assist with referral for psychological counseling through Victim's Assistance, community mental health resources, and/or family's medical health plan. Crisis counseling for child and family is often necessary.

III. CHILD NEGLECT

A. Identification

Growth parameters below expected for age.

1. Lack of medical care for a significant health problem—for example, no medications for asthma, diabetes; no care of severe dental caries.

2. Lack of normal bonding with parent/guardian.

3. Disregard of one or more basic child care needs—for example, not feeding infant/child, child found in street, failure to place child in auto safety seat or belt.

Note: A child may have findings suggesting more than one form of abuse or neglect.

B. Essential Aspects - Caretaker History

1. Does the parent/guardian give a reasonable explanation that is consistent with the pattern and severity of the findings suggesting neglect (and can he/she provide documentation)? For example—has a child who is small for age been worked up for medical or familial causes of short stature/failure to thrive?

C. Evaluation & Treatment

1. Age 0-2 years: skeletal survey should be considered.
2. Nuclear medicine bone scan (or repeat skeletal survey in 2 weeks) if index of suspicion for skeletal injury remains high despite negative initial skeletal survey.
3. MRI scan of head if there is a suspicion for subacute or chronic intracranial injury.
4. Complete physical examination, including inspection of genitalia and search for dysmorphic features.
5. Developmental assessment.
6. Laboratory evaluation: CBC, electrolytes, glucose, urinalysis, urine C&S. Other labs as indicated clinically (e.g., lead level).
7. Nutrition consult/assessment with caloric quantification if possible.
8. Other consults as indicated clinically.
9. Document child's caloric intake, weight gain, and response to hospital staff.
10. Document level of parental involvement and any concerns regarding inappropriate parental behaviors, attachment, statements, or level of knowledge regarding the child, his/her care, or his/her condition.

ATTACHMENTS:

B-1. Presumptive Treatment of STDs in Sexual Assault Victims
B-2. HIV Prophylaxis
B-3. Guidelines for Emergency Contraception

Attachment # B-1

Presumptive Treatment of STD's in Sexual Assault Victims (adapted from CDC Guidelines, 2006)

Children: The risk of a child acquiring an STD as a result of sexual abuse or assault has not been determined. Presumptive treatment for children who have been sexually assaulted or abused is not recommended because: a) the prevalence of most STDs is low following abuse/assault, b) pre-pubertal girls appear to be at lower risk for ascending infection than adolescent or adult women, and c) regular follow-up of children usually can be ensured. However, some children or their parent(s) or guardian(s) may be concerned about the possibility of infection with an STD, even if the risk is perceived to be low by the health-care provider. Such concerns may be an appropriate indication for presumptive treatment in some settings and may be considered after all specimens for diagnostic tests relevant to the investigation have been collected.

Adolescents: Many specialists recommend routine preventive therapy after a sexual assault because follow-up of survivors of sexual assault can be difficult and because these persons may be reassured if offered treatment or prophylaxis for possible infection. The following prophylactic regimen is suggested as preventive therapy.

- Postexposure hepatitis B vaccination, without HBIG, should adequately protect against HBV. Hepatitis B vaccine should be administered to sexual assault victims at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered 1--2 and 4--6 months after the first dose.
- An empiric antimicrobial regimen for chlamydia, gonorrhea, trichomonas, and BV may be administered.

Recommended Regimen:

Follow 206 CDC guidelines (refer to www.cdc.gov)

NOTE: For patients requiring alternative treatments, see the sections in this report that specifically address the appropriate agent. The efficacy of these regimens in preventing gonorrhea, trichomoniasis, BV, and *C. trachomatis* genitourinary infections after sexual assault has not been evaluated. Clinicians should counsel patients regarding the possible benefits, as well as the possible toxicity, associated with these treatment regimens; gastrointestinal side effects can occur with this combination. Providers may also consider anti-emetic medications if prophylaxis is administered, particularly if emergency contraception is also provided.

Other Management Considerations

At the initial examination and, if indicated, at follow-up examinations, patients should be counseled regarding the following:

- symptoms of STDs and the need for immediate examination if symptoms occur and abstinence from sexual intercourse until STD prophylactic treatment is completed.

Attachment # B-2

HIV prophylaxis *(Nonoccupational Postexposure Prophylaxis = nPEP)*[1]

HIV infection has been reported in children whose only known risk factor was sexual abuse. Serologic testing for HIV infection should be considered for abused children. The decision to test for HIV infection should be made on a case-by-case basis, depending on the likelihood of infection among assailant(s). Data are insufficient concerning the efficacy and safety of postexposure prophylaxis among both children and adults. However, antiretroviral treatment (*a 28-day course of highly active antiretroviral therapy –HAART),* is well tolerated by infants and children with and without HIV infection; in addition, children who receive such treatment have a minimal risk for serious adverse reactions because of the short period of time recommended for prophylaxis.

In those cases in which a child presents to a health-care provider shortly after a sexual exposure (i.e., within 72 hours), the assailant(s) are likely to be at risk for HIV infection, and likelihood of compliance with treatment regimens is high, the potential benefit of treating a sexually abused child should be weighed against the risk for adverse reactions. **If antiretroviral postexposure prophylaxis is being considered, a professional specializing in HIV-infected children should be consulted.** If treatment is started, then medication should be given for the full 28 day course of therapy.

Recommendations for Postexposure Assessment of Children within 72 Hours of Sexual Assault

- Review HIV/AIDS local epidemiology and assess risk for HIV infection in the assailant.
- Evaluate circumstances of assault that may affect risk for HIV transmission.
- Consult with a specialist in treating HIV-infected children if postexposure prophylaxis is considered.
- If the child appears to be at risk for HIV transmission from the assault, discuss postexposure prophylaxis with the caregiver(s), including its toxicity and its unknown efficacy.
- If caregivers choose for the child to receive antiretroviral postexposure prophylaxis, provide enough medication until the return visit at 3--7 days after initial assessment to reevaluate child and to assess tolerance of medication; dosages should not exceed those for adults.
- Perform HIV antibody test at original assessment, 6 weeks, 3 months, and 6 months.

Recommendations for Postexposure Assessment of Adolescent and Adult Survivors within 72 hours of Sexual Assault

- Review HIV/AIDS local epidemiology and assess risk for HIV infection in assailant.
- Evaluate circumstances of assault that may affect risk for HIV transmission.
- Consult with a specialist in HIV treatment if postexposure prophylaxis is considered.

- If the survivor appears to be at risk for HIV transmission from the assault, discuss antiretroviral prophylaxis, including toxicity and unknown efficacy.
- If the survivor chooses to receive antiretroviral postexposure prophylaxis, provide enough medication to last until the next return visit; reevaluate survivor 3--7 days after initial assessment and assess tolerance of medications.
- Perform HIV antibody test at original assessment; repeat at 6 weeks, 3 months, and 6 months.

Assistance with postexposure prophylaxis decisions can be obtained by calling the National HIV Telephone Consultation Service (tel: 800-933-3413)

1. U.S. Department of Health and Human Services. Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States. *MMWR.* January 21, 2005 / 54(RR02);1-20.

Attachment # B-3 Emergency Contraception

Plan B is an emergency contraceptive that can be used to prevent pregnancy following unprotected intercourse. Each Plan B packet includes a single course of treatment and consists of two tablets; each tablet contains 0.75 mg levonorgestrel.

To obtain optimal efficacy, the first tablet should be taken as soon as possible within 72 hours of intercourse. The second tablet must be taken 12 hours later.

Taken within 72 hours of unprotected intercourse, Plan B can, when used correctly, reduce the risk of pregnancy by 89 percent after a single act of unprotected sex. Effectiveness declines as the interval between intercourse and the start of treatment increases

When used as directed, Plan B is safe for most women. There have been no serious complications associated with Plan B. Common side effects include nausea, abdominal pain, fatigue, headache, and menstrual changes. Women who are pregnant, have undiagnosed vaginal bleeding, or have an allergy to the product should not use Plan B. Plan B cannot terminate an established pregnancy.

Use of Yuzpe Regimen using other oral contraceptives is acceptable Emergency Contraception if plan B is not available.

Patient should be advised to obtain pregnancy test if no vaginal bleeding in 28 days after completing Emergency Contraception.

NORTH CAROLINA AND SOUTH CAROLINA DSS AGENCIES

You must call the Department of Social Services in the county that the child is a permanent resident of. Numbers for each county are listed below.

COUNTY	PHONE	ADDRESS
Anson	(704) 694-9351 CPS Intake	118 N. Washington St Wadesboro, NC 28170
Burke	(828) 439-2003	700 East Parker Rd. Morganton, NC 28680
Cabarrus	(704) 920-1400	1303 S. Cannon Blvd. Kannapolis, NC 28083
Caldwell	(828) 426-8200	1966-H Morganton Blvd. SW Lenoir, NC 28645
Catawba	(828) 324-9111	3030 Eleventh Ave. Dr., S.E. Hickc NC
Chester	(803) 377-8131 ext. 0	115 Reedy Street Chester, SC 29706
Chesterfield	(843) 623-2147 ext. 1	201 N. Page Street Chesterfield, SC 29709
Gaston	(704) 862-7500 ext. 1	330 N. Marietta Street Gastonia, NC 28052
Iredell	(704) 873-5631	PO Box 1146 Statesville, NC 28687
Lancaster	(803) 286-6914	1837 Pageland Highway Human Services Complex Lancaster, SC 29721
Lincoln	(704) 732-0738	PO Box 130, Lincolnton, NC 28093
Mecklenburg	(704) 336-3150	Wallace H. Kuralt Centre, 301 Billingsley Rd. Charlotte, NC 28211
Richmond	(910) 997-8415	125 Caroline St., Rockingham, NC 28379
Rowan	(704) 638-3175	1236 West Innes Street, Salisbury, NC 28144
Stanly	(704) 982-6100	1000 North First Street, Suite 2, Albemarle, NC 28001
Union	(704) 296-4300	1212 West Roosevelt Blvd. Monroe, NC 28111
York	(803) 684-2315 Dial 0 and ask for CPS Intake	P O Box 261 York, SC 29745

North Carolina and South Carolina Law Enforcement Agencies

Anson County
Sheriff's Office
119 N Washington St
Wadesboro, North Carolina 28170
(704)694-4188

Burke County
Sheriff's Office
150 Government Dr
Morganton, North Carolina 28655
(828)438-5500

Cabarrus County
Sheriff's Office
25 Corban Ave SE
Concord, North Carolina 28025
(704) 920-3000

Caldwell County
Sheriff's Office
2351 Morgantown Blvd. SW
Lenoir, North Carolina 28645
(828) 758-2324

Catawba County
Sheriff's Office
100 B Southwest Blvd
Newton, North Carolina 28658
(828) 464-5241

Cleveland County
Sheriff's Office
100 Justice Place
Shelby, North Carolina 28150
(704)484-4888

Gaston County
Sheriff's Office
PO Box 1578
Gastonia, North Carolina 28054
(704)866-3160

Guilford County
Sheriff's Office
400 W Washington St
Greensboro, North Carolina 27401
(336) 641-3690

Iredell County
Sheriff's Office
PO Box 287
Statesville, North Carolina 28687
(704)878-3180

Lincoln County
Sheriff's Office
700 John Howell Memorial Dr.
Lincolnton, North Carolina 28092
(704)732-9050

Mecklenburg County
Sheriff's Office
700 E 4th St
Charlotte, North Carolina 28202
(704)336-2543

OR Charlotte Mecklenburg Police Department
704-353-1000 or 911

Richmond County
Sheriff's Office
#1 Court St
Rockingham, North Carolina 28379
(910)997-8283

Rockingham County
Sheriff's Office
1086 NC 65
Wentworth, North Carolina 27375
(336)634-3232

Rowan County
Sheriff's Office
232 N Main St
Salisbury, North Carolina 28144
(704)636-1011

Rutherford County
Sheriff's Office
198 N Washington St
Rutherfordton, North Carolina 28139

Union County
Sheriff's Office
3344 Presson Rd
Monroe, North Carolina 28112

Stanly County
Sheriff's Office
201 S. Second Street
Albemarle, North Carolina 28001
(704) 283-3844

Union County
Sheriff's Office
3344 Presson Road
Monroe, North Carolina 28607
(704) 283-3844

Watauga County
Sheriff's Office
330 Queen St
Boone, North Carolina 28607

South Carolina Agencies

Chester County
P.O. Box 727
Chester, SC 29706-0727
(803) 581-5131

Chesterfield County
Courthouse, 200 W. Main St
Chesterfield, SC 29709
(843) 623-2101

Lancaster County
P.O. Box 908
Lancaster, SC 29721-0908
(803) 283-4186

York County
1675-2A York Highway
York, SC 29745
(803) 628-3059

10-10-2000 11:13am From-DISTRICT COURT JUDGE 7043428321 T-90 P 001/003 F-281

STATE OF NORTH CAROLINA

IN THE GENERAL COURT OF JUSTICE

COUNTY OF MECKLENBURG

DISTRICT COURT DIVISION

ADMINISTRATIVE ORDER

RETENTION OF CUSTODY OF JUVENILE SUSPECTED TO BE ABUSED PURSUANT TO NCGS §7B-308

BY_____

Pursuant to North Carolina General Statutes §7B-308, it is hereby ordered that Carolinas Medical Center, Presbyterian Hospital, Mercy Hospital, Mercy Hospital South, University Hospital and Presbyterian Matthews Hospital are authorized to retain custody of a juvenile (anyone under the age of 18) when the examining physician certifies in writing that the juvenile is suspected of being abused and: (a) that the juvenile should remain for medical treatment; or (b) that according to the juvenile's medical evaluation, it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker.

Custody assumed by this authority may not exceed twelve hours from the time and date contained in the Examining Physician's Certification without an additional Court Order.

When this action is taken, the physician or administrator of the hospital shall immediately notify the parent, guardian, custodian or caretaker of the juvenile and the Director of the Department of Social Services or his designee.

The purpose of this order is to allow for the legal retention of custody in emergency cases long enough for the Department of Social Services to investigate the case and, if appropriate, seek a Court Order for custody in accordance with North Carolina law.

Examining physicians shall utilize the Examining Physician's Certification form on the reverse side of this page whenever a juvenile is retained under the authority of this Order.

A copy of the Examining Physician's Certification must be given to the juvenile's parent, guardian, custodian or caretaker; the Department of Social Services; and the Chief District Court Judge (700 E. 4th Street, Suite 3304, Charlotte, North Carolina 28202), for placement in the juvenile's judicial records.

A copy of this Administrative Order must also be given to the parent(s), guardian, custodian or caretaker.

Each hospital shall maintain a file containing copies of all Examining Physician's Certifications executed under the authority of this Order at that hospital.

This Order replaces the Letter of Authorization issued October 5, 1993, by then Chief District Court Judge James E. Lanning.

This the 18 day of October, 2000.

William G. Jones
Chief District Court Judge

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002654

EXAMINING PHYSICIAN'S CERTIFICATION

Name of Juvenile: _____ Date of Birth: _____

Address: _____

_____

Name of Parent, Guardian, Custodian or Caretaker: _____

_____

Address: _____

_____

The undersigned examining physician hereby certifies that there is good cause to suspect that this juvenile is abused, and:

☐ should remain in _____ (name of facility) for medical treatment;

OR

☐ it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker.

The basis for this determination is:

_____

_____

_____

Date: _____ _____
Examining Physician

Time: _____

The juvenile's parent, guardian, custodian or caretaker was given an executed copy of this certification at _____ a.m./p.m. on _____.
(date)

DSS was notified of the execution of this certificate at _____ a.m./p.m. on _____.
(date)

An executed copy of this certificate was mailed to the Chief District Court Judge at 700 E. 4th Street, Suite 3304, Charlotte, NC 28202 on _____.
(date)

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002655

Attachment D
PR 110.03, Juveniles Suspected of Being Abused or Neglected

CERTIFICATION OF NECESSITY FOR RETENTION OF CUSTODY

Name of Juvenile: _____ Age: _____

Address of Juvenile: _____

_____

Name of Parent, Guarding, or Custodian: _____

Address: _____

_____

The undersigned physician has examined this juvenile and that examination reveals the following injuries / illness.

_____

_____

_____

_____

Based on the foregoing and additional facts set out below, the undersigned physician hereby certifies that:

☐ This juvenile should remain in _____ (name of facility) for medical treatment.

☐ In my medical evaluation, it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker.

Additional reasons (if any) for retention of custody:

_____

_____

_____

_____

Date: _____

Time: _____ Signature: _____

Carolinas HealthCare System
CERTIFICATION OF NECESSITY FOR RETENTION OF CUSTODY

PR 110.03, revised 05/11

ADDRESSOGRAPH PLATE

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002656

Attachment E

CHAPTER 90. MEDICINE AND ALLIED OCCUPATIONS
ARTICLE 1A. TREATMENT OF MINORS
PART 1. GENERAL PROVISIONS

Go to the North Carolina Code Archive Directory

N.C. Gen. Stat. § 90-21.5 (2010)

§ 90-21.5. Minor's consent sufficient for certain medical health services

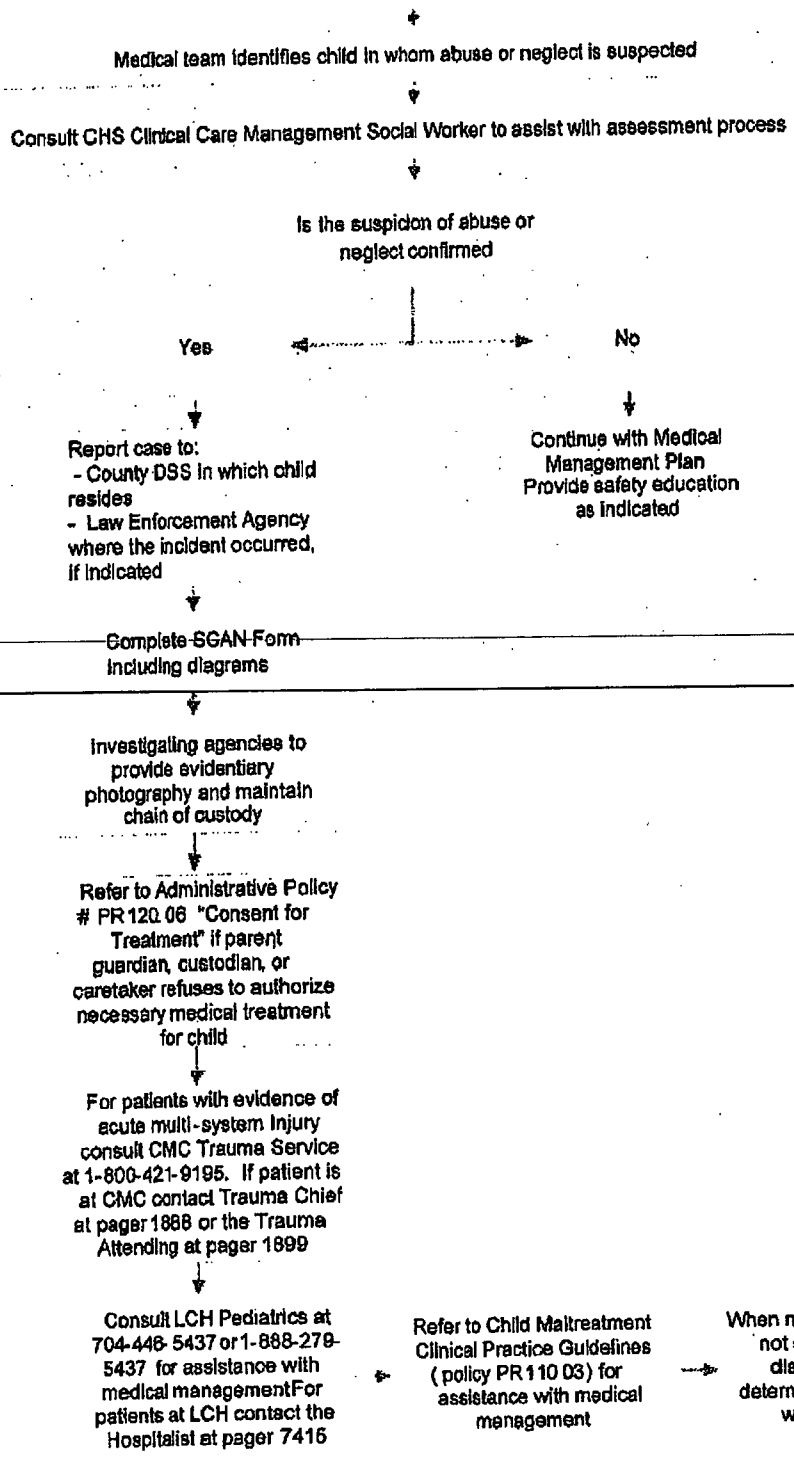
(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-223. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-223.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.

HISTORY: 1971, c. 35; 1977, c. 582, s. 2; 1983, c. 302, s. 2; 1985, c. 589, s. 31; 1985 (Reg. Sess., 1986), c. 863, s. 4; 2009-570, s. 10.

Attachment F

Child Abuse and Neglect Algorithm



EXHIBIT

"4"

Kayla Lythgoe
Michael Carduff
Case Review

Child: Owen C[redacted] DOB[redacted]
Grandmother: Charlotte Williams
Step Grandfather: Larry Williams

12/6/09 Intake: 17:01 p.m. (On Call)

Maltreatment:
R/S 2 month old baby has subdural hematoma (size 3 mm and 2mm); There is a Fatx Subdural Hematoma which raises the possibility of Non accidental trauma; parents behavior has been appropriate with Child.

Client Characteristics
Owen was initially admitted to PMC on 12/4/09 and was transferred To CMC – Levine Children Hospital; CT scan show 2 Subdural Hematomas (sizes 3 mm and 2mm) there is a fatx subdural hematoma

Caretaker Characteristics
Parents observed to be appropriate/concerned, parents took baby for Medical treatment on 11/28/09, 12/2/09 and 12/4/09, no mental, Physical, spouse abuse known, no known prior CPS, parents reside With maternal grandmother

Social/Economic Factors
Both parents are employed and live together, no known marital, Financial problems noted

Reporter:
Carol Smith – Levine Children's Hospital

12/6/09 Face-to-Face 7:45 p.m. at Levine Children's Hospital
On Call Worker: Chandra Tyler/Supervisor: Lola Sutherland
Present: Kayla, Michael, Jennifer Carduff, PGM and Brian Carduff Paternal uncle; CMC Sitter
Interview: Kayla Lythgoe
11/28/09: noted change in behavior; sleep a lot/scream when awake Nonstop; took him to Riverview 24 hour clinic; doctor said nothing Wrong with him; behavior continued
12/1/09 went all day without urinating; (Michael
appt scheduled for 12/2/09
Sunshine Pediatrics, Dr. Paxor; diagnosis throat infection and minor Cold; no meds prescribed
12/4/09: Kayla stated pulling in driveway and Michael came out of House said Owen just went limp but still breathing; rushed to PMC
12/5/09: Kayla stated transferred to CMC – Levine
Charlotte Williams, her mother watch Owen; sleep in back-n-play In their room; state no when asked if Owen had hit his head/fell;

DSS-PMW 0163

EXHIBIT 4

EXHIBIT

"5"

Notice in November he had a small flat brownish bruise on left side
Of head, asked Michael if he knew where it came from, stated no
Stated Owen's head turns and jerks around during tummy time on
The floor;

Interview: Michael Carduff
Stated Owen's behavior has been different since 11/28/09; he was
Watching Owen on 12/4/09 by himself; he was sleeping a lot, then
Stretched out, turning red and went limp; no knowledge of any injury

Interview: Jennifer Lythgoe
State she and her husband has watched Owen briefly when parents
Ran an errand; Brian has never watched Owen; but has been in the
Home with both parent and watch Owen when they did things
Around the house;

Interview: CMC Nurse
Worked asked if she relieved the Sitter; nurse thought the reason
Worker called was to relieve Sitter; because DSS make the decision
Of whether to relieve the Sitter. Worker explained called because of
Concern the reports showed a fatx subdural hematoma and raises
The possibility of non accidental trauma. Nurse stated SW was
Not suppose to be calling for that reason;

12/6/09 Safety Plan: Follow medical advice of hospital and doctor
Recommendations, not to remove child from hospital until
Medical discharge
Signed by Kayla and Michael and DSS worker Chandra Tyler

12/6/10 Acknowledgement: Signed by Kayla and Michael
Dirvondra Hill signature and dated 12/709

12/7/09 Face to Face with child/client attempted Dirvondra Hill
[redacted] 2 men outside talking; informed family
Not home; knocked at mobile home; no sound from inside; called
Phone number [redacted]; voice mail of Charlotte Williams
Left message to call Case Manager

12/7/09 Staffing with Supervisor Krista Hinnant
See DSS 3062 Case staffed with Legal

12/7/09 Staffing with Supervisor Krista Hinnant
Current Situation: Owen has two subdural hematomas; one would
Indicate non accident trauma; SW has concerns because CT scan
Shows non-accidental trauma; no doctor is saying injuries are non

EXHIBIT 5

EXHIBIT

"6"

Accidental, Hospital has Sitter; parents contact supervised; Nurse Said it is non-accidental; grandmother saw a bump on baby's head A few days ago; baby with dad and uncle; Owen is ready for Discharge; Recommendations: Get medical records; Review records; Refer to Law Enforcement; Law Enforcement incident Public Index; Follow up talk with doctor; meet with grandmother (assess); go to Home and assess home; talk to Grandmother separately; any Concerns talk to Laura McDowell, does doctor think trauma is Non-accidental (Get Release of Info signed.

Krista — Collateral Contact: Laura McDowell, SW at Levine
Krista informed Laura that DSS would need to speak with doctor Or hospital SW could speak with doctor to determine if Owen's Hematomas were accidental or nor. Laura will follow up with Doctor

Krista — 11:50 a.m. Received a phone call from Laura Newmark, she talked With Pediatric staff at this time the hospital cannot determine Whether the injuries are accidental or non accidental, Owen's eye Exam and Skeletal Survey were negative; going to repeat CT scan Today because Owen's head appear to be swollen, family has no Clear history of trauma; however hospital cannot rule out trauma Parents are young and hospital mostly has concerns for lack of Supervision, unknown if Owen discharged today or tomorrow and That will be determined by results of Owen's CT scan; at this point There are no obvious finding of abuse/neglect; family will need to Follow up with skeletal in 2 weeks; parents will be able to do that Back home and will not need to come back to Charlotte; doctor Assigned is Dr. Cheryl Courtlandt; Dr Courtlandt stated she cannot Determine if the injuries are an accident or not at this point; Krista advised Laura that she would staff the case with legal Department and get back with her asap with a discharge plan for The baby.

3:30 p.m.Krista talked with Laura Newmark, SW at Levine, advised Laura the case had been staffed with legal and Owen should be discharged to parents and DSS will follow up with a home assessment, Laura stated Owen's second CT scan was stable; Laura will notify Krista when Owen is discharged

3:34 p.m. Krista received message from Laura McDowell that Owen Will be discharged today is going home with the parents

12/08/09 — Face to Face with child/client attempted Dirvondra
No vehicle in yard, no answer at the home, called family from car Number listed on intake; left message to contact case manager

EXHIBIT 6

EXHIBIT

"7"

Page 13

whom abuse or neglect is suspected; right?
MS. BROOKS HOLMES: Objection.
THE WITNESS: Yes.
BY MR. HOOD:
Q Then it says, "Consult CHS clinical care management social worker to assist with assessment process." Do you see that?
A Yes.
Q And you were part of that CHS clinical care of management social worker team, weren't you?
A Yes.
Q And then it says, "Is the suspicion of abuse or neglect confirmed?" Do you see that?
A Yes.
Q And then there's a -- there's a fork in the road, under "no" it says what to do and under "yes" it give some other things; right?
A Yes.
Q And under "yes," could you read what it says under "Report case to"?
A "Report case to county DSS in which child resides, law enforcement agency where the incident occurred if implicated."
Q Okay. And DSS was notified, weren't they?
A Yes.

Page 14

Q And so suspicion of abuse or neglect was confirmed; right?
A I wouldn't disagree with that. I know the algorithm says something, but -- the suspicion was not confirmed, there had not been a full workup yet.
Q Okay. Why did you report it to DSS?
A Any concerning injury that validates a workup gets reported to DSS.
Q Where is that in the algorithm?
A I don't know. I did not write this algorithm.
Q Okay. This is written for the safety of children; right?
A That would be my assumption.
Q And it was written by Levine Children's Hospital or somebody there; right?
A I don't know who wrote it.
Q Let's go over the other stuff that doesn't -- doesn't really come within the algorithm that was done in this case.
Was there a complete scan form including diagrams done?
A I don't know.
Q Okay. Are any of these things done?
A During the admission?

Page 15

Q For -- for the child in December of 2009.
A I don't know, off the top of my head. I would either have to go through the chart or --
Q I'll represent to you, and I'll show it to you, that -- that a lady by the name of Myers, who was the child maltreatment coordinator for this hospital was involved in the care of this case.
A She is the nurse, yes.
Q And you're not going to have somebody involved in that if you didn't suspect child maltreatment; right?
A If there is a workup because they're concerned about abuse, she would be involved.
Q Let me show you something from DSS.
(Discussion off the record)
(Case review marked as Plf's Exh 3 for identification.)
BY MR. HOOD:
Q I'll represent to you that this is what was given to us by DSS. These were documents produced to us by DSS; okay?
A Mm-hmm.
MR. HOOD: And then let's mark as 4 something else from DSS.
(Case Transfer and/or Case Staffing marked

Page 16

as Plf's Exh 4 for identification.)
MR. HOOD: Look at the second page of this.
MR. TODD: Which one?
MR. HOOD: Exhibit 4.
BY MR. HOOD:
Q This is something that was provided to us by DSS. It says, "Owen has two subdural hematomas, one would indicate non-accidental trauma, parents appropriate." Do you see that?
A Yes.
Q And then that, the one below it gives some history. It says, "Parents took baby to PNC. PNC sent child to Levine's. She has concerns because CT scans shows non-accidental trauma, no" -- and I think that's "no problem in saying it is non-accidental." I don't know what --
A I think that says "no doctor."
Q "No doctor is saying it's non-accidental."
Now, I know you're not a medical person. This is a social worker from DSS.
A Sure.
Q As a social worker from DSS, is there a standard when you have two subdural hematomas that it is consistent with non-accidental trauma?

EXHIBIT 7

EXHIBIT

"8"

LCH PEDIAT CS
INPATIENT INITIAL ASSESSMENT

Medical Decision Making

LABS:

135	106	11
4.9	22	0.2

(197

tProt: 5.8
Albumin: 3.9
Calcium: 10.9
TBili: 0.2

ALP: 283
AST 35
ALT 32

CULTURES: ☐ Blood ☐ Urine ☐ CSF ☐ Other

CSF
WBC 3444
RBC 250000
Segs: 41%
Lymph 59%
gluc: 61

5.6) 76 (418
225

RADIOGRAPHIC IMAGES:

CXR: wnl

UA: Leuk ⊖ Ketones (1+)
Nitrite ⊖ Leuk (trace)

ASSESSMENT/PLAN:

2mo old ♂ w/ no sig pmh here w/ a clinical ALTE

① Neuro: Concern for possible SE. Mom had fall already w/ what appears to be a traumatic tap. Nothing on exam to suggest meningitis. Low concern for intracranial injury. No CT @ this time.

② CV: Stable currently. Has had no hypotension/bradycardia noted.

③ Pulm: Stable - nasopharyngeal swab for viral DFA.

④ FEN/GI: ?GERD. May have been back-arching w/ reflux. Will institute reflux precautions. Diet - formula. Low suspicion for intussusception.

⑤ Renal: Low UOP over last 24h. Will IV bolus & maintenance NF

⑥ Heme/ID: DFA (-); low concern meningitis; infectious etiology unlikely. Anemia, normocytic, will follow trend on repeats.

☐ Discussed impression and plan with patient/family; questions answered and understanding of plan demonstrated.

SIGN / PRINT NAME: Eric Schenfeld PAGER: 6732

ATTENDING Assessment/Plan (Key Elements): ☐ see separate documentation

☒ I have examined and discussed this patient with Drs. Schenfeld. Please see their notes for details.

Pertinent findings from my evaluation include

2mo ♂ c ALTE + head bleeds on head CT. Retinal hemorrhages. Hx trauma according to mother + father. PE: ⊖ slightly bulging fontanelle, remainder PE WNL. A/P: 2mo ♂ ALTE, R/O NAT dip sepsis wu as well. Initiate NAT protocol. Flu bld, urine, CSF cx's. Flu Opth's + Neurosurg rec's. Sitter in room until cleared by DSS/Child Maltreatment Team.

SIGN NAME: Sarah Steel DATE: 12/5/09

PRINT NAME: SARAH STEEL TIME: 1:50P

09339-00393
C000545-02-19
C[redacted] OWEN [redacted]
ATT PHY: 66247 CHIPS,TEAM A
12/05/09 DOB [redacted]

EXHIBIT
8
581

CMC (12.05.09) 0065

EXHIBIT

"9"

GM saw ... baby was
a few days ago – uncle Baby's follow doctors
with Dad. Baby is ready for discharge

Follow up on previous Recommendations: Hospital has a sitter.
Parents are having supervised
contact w/ baby. Parents also
took child to Riverview. Parents
said they noticed a bruise in
baby's head in November – neither
of them knew what happened.
Parents have witnessed no injury
to baby. Nurse said it is nonaccidental

Recommendations from Staffing:

- Get medical – Levines, CMC, PMC, Riverview & Sunshine Peds
- [redacted] Requested)
- [redacted]
- [redacted]
- Follow up and talk w/ doctor
- Meet w/ GM (assess)
- ✓ Go to home and assess home.
- Talk w/ GM separately – any concerns?
- Talk to Laura M[redacted] (704) 355[redacted] – Peds trauma – non accidental – Release of info.

For Child Welfare Cases: Date of Diligent Search for Absent Parent or Other Relative and Outcome Search: ______

[signature] 12/7/09 | Kristin M. [signature] 12/7/09
Case Manager | Date | Supervisor | Date

Transfer case to ______ from ______

[signature] 12/7/09 | [signature] 12.7.09
Sending Worker's Signature Date | Sending Supervisor's Signature and Date

______ | ______
Receiving Worker's Signature Date | Receiving Supervisor's Signature Date

DSS Form 3062 (Oct 04) Edition of APR 91 is obsolete.

SCDSS 0996

EXHIBIT 9

EXHIBIT

"10"

Page 9

A Sure.
Q Okay. And after being admitted to -- I'm going to call it L -- LCH.
A That's fine, yes.
Q Levine Children's Hospital. If I use the term "LCH" or "Levine Children's Hospital" or "Levine," I'm talking all about the same entity.
A Right.
Q Okay. So after being admitted to LCH, the child was eventually discharged back to his parents; right?
A Yes.
Q And you're aware that approximately 30 days after that, the child came back to Levine Children's Hospital and was catastrophically brain injured?
A Yes.
Q And if he had never been put back with his parents, back to the abuser, the child -- it would have never happened, would it?
MS. BROOKS HOLMES: Objection.
MR. FRAWLEY: Object to form.
THE WITNESS: I can't answer that.
BY MR. HOOD:
Q Why can't you answer it?

Page 10

A Because I don't know what would have happened.
Q Okay. Let's -- let's -- let's break it down a little bit for you.
He doesn't go back to his parents on December the 8th, he goes into foster care; right?
MR. TODD: Objection.
BY MR. HOOD:
Q Or with another relative?
MR. TODD: Objection.
MR. FRAWLEY: Same objection.
MS. BROOKS HOLMES: Same objection.
BY MR. HOOD:
Q You can answer.
A I don't have any say as to where he goes upon discharge, as a hospital employee.
Q You work hand-in-hand with a state agency, you-all were retained to determine what happens with a child where there is suspected child abuse involved.
A I --
MR. TODD: Objection.
BY MR. HOOD:
Q You can answer.
A I am a liaison between the medical team

Page 11

and DSS.
Q Okay. As a liaison, you are the person that helps get whatever the medical discharge is going to be; right?
MR. TODD: Objection.
THE WITNESS: No.
BY MR. HOOD:
Q Okay. As the liaison, you work as a person between the state agency and the medical doctors?
A Yes.
Q And then you help those two people come together to determine what's in the best interest of the child?
MR. TODD: Objection.
THE WITNESS: No. I share information on the clinical status and what's going on with the patient with DSS, who has the ultimate discharge plan put in place.
BY MR. HOOD:
Q Okay. But I thought that you, according to your own algorithm, that you-all had to do it together?
A I give them information. I don't control the final decision.

Page 12

Q Who controls the final decision?
A DSS.
Q Okay. Let me look at your algorithm.
(Child Abuse and Neglect Algorithm marked as Plf's Exh 2 for identification.)
THE WITNESS: Could I get to look at it?
BY MR. HOOD:
Q You're now looking at Plaintiff's Exhibit 1, which are some -- looks like typewritten or some electronic-type of documentation about this baby and then -- that's Exhibit 1, and then Exhibit 2 is a Child Abuse and Neglect Algorithm from Levine Children's Hospital; right?
A Are you asking me? Yes.
Q Yes.
A Yes.
Q Okay. Now, I'm going to go through 2, and then we'll go to 1; okay?
A Okay.
Q Number 2, it says, "Medical team identifies child in whom abuse or neglect is suspected."
Do you see that?
A Yes.
Q And in this case they identified a child

EXHIBIT 10

EXHIBIT

"11"

Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 05:41 pm

Account No	Name	Unit Number	Birthdate
09339-00393	C[redacted],OWEN [redacted]	000545-02-19	[redacted]

(1)Date : 12/06/09
(2)Init : KAH
(3)Planning Code : CPSI-CPSI-CHILD PROT SVC INITIAL REFER
(4)Referred From : LCH

```
          1         2         3         4         5         6         7
01234567890123456789012345678901234567890123456789012345678901234567890123456
01 12/06/2009 MSW note continued...after she staffs the case c her supervisor
02 Baby is not for d/c today, possibly will be d/ced tomorrow. Baby does have
03 SC Medicaid, WIC, mom has foodstamps. Both parents work, MGM watches baby
04 when parents are working. Pt's bedside RN Sara did report that MGM did
05 tell her privately that when she had picked baby up from dad and uncle
06 that she noticed baby had a bump on his head, she asked dad and uncle
07 about this and dad and uncle stated that they had no idea why this
08 happened.  MSW will leave note for weekday MSW.
09
10 Katie Harrison, MSW p 2537
11
12
Edit Notes (Y/N)?--
```

EXHIBIT
11
587

CMC (12.05.09) 0096

EXHIBIT

"12"

DATE	TIME	RECORD PROGRESS OF CASE, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, AND INSTRUCTIONS TO PATIENT.
12/7/09		NSurg
	1000	Family reports hx of [illegible] po
		Chronic reflux [illegible] feeds.
		Parents have noticed [illegible],
		uncertain if present from birth.
		Happy, active. MAE=
		In [illegible] position at [illegible].
		HC- 42.5cm
		- will obtain HC graph from Peds office
		Dr. Baxter (803-980-7337)
		Left message
		[signature] NP
		[signature]
		1-2-10 1115
12-7-09		Neurosurg
	1845	Alert. Doing well overall. Repeat
		CT shows stable extra-axial collections
		(R) denser than (L). OK to discharge
		under supervision — will need to
		see in f/u 2-3 weeks. Should be
		instructed prior to disch re. s/s of
		↑ICP.
		[signature]

ABBREVIATIONS

USE	DO NOT USE
Units	u or U
International units	IU
X mg (Never use a trailing zero)	X.0 mg
0.X mg (Always use a leading zero)	.X mg
daily	QD
every other day	QOD
Morphine	MS or MSO_4
Magnesium Sulfate	$MgSO_4$

Carolinas HealthCare System
PROGRESS RECORD
(3/07)

09339-00393
C000545-02-19
C[redacted]OWEN [redacted]
ATT PHY: 66247 CHIPS TEAM A
12/05/09 DOB: [redacted]

EXHIBIT
12
589

CMC (12.05.09) 0039

EXHIBIT

"13"

DOCUMENT NAME: Suspected Child Abuse/Neglect Form-Text
SERVICE DATE/TIME: 12/8/2009 10:02 EST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: MYERS ,LYNNE RN (12/8/2009 10:32 EST)
SIGN INFORMATION: MYERS ,LYNNE RN (12/8/2009 10:32 EST)

SCAN (Suspected Child Abuse/Neglect) Entered On: 12/8/2009 10:33 EST
Performed On: 12/8/2009 10:02 EST by MYERS , LYNNE RN

SCAN Documentation
SCAN Related Visits: Child Maltreatment Coordinator
Document Reportable Interaction: Yes
Reportable Interaction Detail: Awaiting safety plan from DSS.

MYERS , LYNNE RN - 12/8/2009 10:32 EST

DOCUMENT NAME: Suspected Child Abuse/Neglect Form-Text
SERVICE DATE/TIME: 12/7/2009 10:00 EST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: MYERS ,LYNNE RN (12/7/2009 10:00 EST)
SIGN INFORMATION: MYERS ,LYNNE RN (12/7/2009 10:00 EST)

SCAN (Suspected Child Abuse/Neglect) Entered On: 12/7/2009 10:01 EST
Performed On: 12/7/2009 10:00 EST by MYERS , LYNNE RN

SCAN Documentation
SCAN Related Visits: Child Maltreatment Coordinator
Document Reportable Interaction: Yes
Reportable Interaction Detail: Pt sleeping w/ mom in chair. Mom states staff discussed safe sleeping & she understands the danger of her behavior.

MYERS , LYNNE RN - 12/7/2009 10:00 EST

DOCUMENT NAME: Pediatric Frequent Checks Form - Text
SERVICE DATE/TIME: 12/8/2009 12:20 EST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: MILLER ,SARAH E RN (12/8/2009 14:39 EST)
SIGN INFORMATION: MILLER ,SARAH E RN (12/8/2009 14:39 EST)

Pediatric Hourly Checks Entered On: 12/8/2009 14:42 EST
Performed On: 12/8/2009 12:20 EST by MILLER , SARAH E RN

Hourly Checks
Pediatric Hourly Checks: Reassess, no change from previous assessment, Family at bedside, Other: Patient continues to be held per mom in NAD. Discharge instructions gone over and given to parents with questions asked/answered and understanding verbalized. No further needs stated @ this time.

MILLER , SARAH E RN - 12/8/2009 14:39 EST

EXHIBIT

"14"

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A No.
Q You're going to get somebody who's qualified to do that, correct? And I'm not going into what your attorneys told you. But are you going to get someone with a little more spurs medically than you to interpret those records?
A I would do that if - - - yes.
Q That would be a reasonable thing to do, correct?
A Yes.
Q And at that point, you would defer to that expert's opinion as to what Levine's was saying, correct?
A Yes.
Q Dr. Bailey told you that there were only two ways you could have a situation like this. One was trauma at birth and the other was the shaken baby. And he's actually giving you a gesture - - -
A Yes.
Q - - - for shaken baby. Did he define for you what trauma at birth he was talking about?
A He did not.
Q Did he tell you that with a child, a newborn's, the malleableness of the head and the fact that sometimes they come out with cone heads for the first few hours, that a normal vaginal delivery could have a traumatic impact on a child's head,

Page 134

that that could take a couple of months to resolve?
A He did not tell me that.
Q Okay. I mean, I'm not sure that's the case but is that a possibility based on what he told you?
A Based on what he told me, I was reading into what he was implying.
Q And based on what he told you and the fact that you've got a child who is about three months old then and is three months removed from that normal vaginal delivery, you were pretty much discounting the possibility of trauma at birth and you were considering more a shaken baby syndrome issue at that point, correct?
A Because of what Dr. Bailey told us, yes.
Q He didn't tell you trauma at birth was being excluded did he?
A He did not.
Q Have you spoken with anyone from SC DSS about this case other than Shaundra Tyler, that first night, and Ms. Hill?
A We have spoken to several more people because of the prior when we went to civil court for Kayla.
Q For Kayla. Tell me about that.
A Well, maybe I have my dates mixed up. Can you repeat the question?

Page 135

Q Sure. With regard to the December 4th first injury up to the January 11 second injury, when these two injuries were bracketed, have you spoken with anybody from DSS other than Shaundra Tyler and Divandra Hill?
A No.
Q Now, I understand you had some other connection with DSS thereafter, one - - -
A After that.
Q - - - was the rocking chair thing - - -
A Right.
Q - - - and maybe the custody issue later on.
A Right.
Q But have you spoken with anybody from DSS with regard to what they should or should not have done in the time period between December 6th when they were called in and the January 11, 2010, second injury?
A No, sir.
Q Do you know if Mr. Williams has?
A I don't believe he has.
Q And I'll be asking Mr. Williams that same question. But you all are husband and wife in a situation involving your grandson - - -
A Right.

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Q - - - and would it be expected from you that had he spoken with somebody from DSS he would have told you that he'd done that?
A Yes.
Q And he's not told you that he's done that?
A Correct.
Q Mr. Todd asked you a question. I think he led with do you have videos of Owen, I guess, from his birth up through the first injury. And my recollection, and I don't mean to mischaracterize, is that you looked a little confused and then he threw in pictures and you said oh, yes, we have that. Now, there could be two things there. It could be videos and there could be pictures or there could be both. Do you have videos of Owen from his birth up through that second injury?
A Yes.
Q And are these videos that you would have taken or these the videos that Kayla had made mention of when we took her deposition? She indicated there may be some videos. Are the videos you're speaking of your own videos or are those the ones that she would maybe talking about?
A They were Kayla and Michael's videos.
Q So if we were to send a request to produce those

EXHIBIT

"15"

was?
A Owen was on the -- I think the intensive care unit at Levine. He was in a room.
Q Was there a sitter in the room?
A I don't recall. Everything was just happening so fast, and I don't recall whether there was one or not.
Q How long did you stay when you went to Levine's your first visit?
A Probably stayed through the night.
Q Did you learn what Owen's condition was?
A Not at that point, not on that first - - - no, not on that first day.
Q All right.
A No.
Q The first day, was it a Saturday?
A I think it was.
Q And I guess you were going to have to preach the next morning?
A On Sunday, yes.
Q According to the record Owen was admitted to Levine's at 4:45 in the morning on December the 5th. I got a calendar here and see if I can - - - I think the 5th was Saturday.
A Saturday, yeah.

Q So you got to Levine some time on Saturday, - - -
A Probably.
Q - - - you think late Saturday afternoon?
A Late Saturday.
Q When you got there do you remember what the concerns were about Owen?
A Yeah, we had concerns. We were just trying to figure out what had happened to Owen. We didn't know really exactly what was going on at that time.
Q At that time had he been diagnosed with having the small subdural hematomas?
A Yes. Well, I remember the - - - I remember a physician being in there that had some type of light or something that was trying to look behind his eyes at that time. I do remember that.
Q Do you know what kind of doctor that was? Was he a neurosurgeon, or neurologist, or ophthalmologist, or do you know?
A Probably an ophthalmologist I would think is checking behind the eyes.
Q Are you guessing because he was looking in the eyes? Do you remember him saying I'm Doctor so-and-so, I'm an ophthalmologist?
A No, I don't remember.
Q So you're just making an assumption that he's an

ophthalmologist because he's looking in the eyes?
A Correct.
Q Did you have any discussions with that doctor?
A It seems like the doctor was telling us that, at that time, that they had seen some blood behind the eyes.
Q And this was at Levine's?
A Right.
Q Do you remember any discussions about any concerns about some kind of abuse to Owen?
A Well, Dr. Bailey came in, I don't remember what Dr. Bailey's first name was, but Dr. Bailey was in the - - - came in the room and we questioned him what had taken place with Owen. And he said that it could be one of the two things. He said it could have happened at birth but pretty much ruled that out. And then he threw his hands up like - - - like a shaking motion and said shaking. I remember that very well.
Q And what day was that?
A That was probably - - - that may have been Saturday. It may have been later Saturday.
Q Do you know what kind of doctor Dr. Bailey was, his specialty?
A A neurologist.

Q When Dr. Bailey said that did that cause any concern to you that someone had abused Owen?
A Well, I didn't know at the time whether - - - whether someone had abused him or what because he never determined - - - he never gave us specifically what had happened to Owen. He never said anything - - - he never gave us any specifics on what happened to Owen at that time.
Q So you think that Dr. Bailey, who's name you remember, came in - - -
A Right.
Q - - - while you were there - - -
A Right.
Q - - - and you think it was that Saturday?
A Yes.
Q And he said something about there being blood behind his eyes?
A He didn't say that.
Q Oh, okay.
A The other doctor said that.
Q Did you observe Dr. Bailey doing in exam of Owen.
A At that time, yes, he was - - - I don't recall exactly what he did but he had - - - I'd assume he was doing an exam on him. I'm not sure.
Q And after he did the exam, he had a discussion with

EXHIBIT 15

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Q When you have a child who has these subdural hematomas and has some of the risk -- the parents have some of the risk factors, how do you err on the side of the caution if it's either accidental versus non-accidental?

MR. TODD: Objection.

THE WITNESS: By taking the steps that we did; by asking for a child maltreatment evaluation; for getting the child a maltreatment physician involved; from getting Department of Social Services and law enforcement involved. That's how you err on the side of caution.

BY MR. HOOD:

Q Okay. And so you would have gotten the pediatric ophthalmology consult?

A Yes.

Q And that came back negative?

A Negative.

Q Although you don't know how it was done?

A No.

Q Would you have gotten a pediatric neurosurgery consult --

A Yes.

Q -- with Dr. McClanahan?

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A Yes.

Q And he would have -- it appears that somebody with him would have ordered the CTs and they would have been looking at the CTs and they would be medically treating the effects of the subdural hematoma?

A Or evaluating if they need treatment.

Q Right, evaluating.

But the bottom line is that the CHIPS teams, of which you were the attending physician, would have been the responsible party for determining if the child was appropriate for discharge or not?

A I would be the appropriate person to determine if the child was medically cleared for discharge.

Q Okay. Now, there are two components of medical discharged, aren't there? I mean -- and when I had say that, what I'm asking is, you have to be medically stable; right?

You agree with that?

A Yes.

Q And then in regard to child -- either suspected or potential child abuse or trauma, you also have to determine that it is safe for the child

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to be discharged back into the home?

A That's not my determination.

Q Okay. Let's look at -- I'm going to ask you to look at -- yeah, I think it's in this stuff right here.

A Okay.

Q I think it's -- I think it's Exhibit 9 and Exhibit 8 and Exhibit 7.

Exhibit 8, Exhibit 9 and Exhibit 7.

Exhibit 7 is simply an administrative order for Retention of Custody for Juvenile Suspected of Being Abused Pursuant to North Carolina General Statutes; right, right?

A Yes. I don't know what this form means, but yes, I guess that's the heading of this form.

Q Okay. These are attachments to a Child Abuse and Evaluation Policy at Carolinas Healthcare System.

And Number 8 is the Certification of Necessity for Retention of Custody.

Do you see that form?

A Yes.

Q Okay. And then the next form is Examining Physician's Certification.

A Yes.

Q And under that it says, "The undersigned

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examining physician hereby certifies there is good cause to suspect that the juvenile was abused and should remain in blank, name of facility, for medical treatment or it is unsafe for the juvenile to return to his parent, guardian, custodian or caretaker."

Do you see that?

A Yes.

Q So do -- does the physician at Levine Children's Hospital have the ability to state that it's unsafe for a juvenile to return to his parent, guardian, custodian or caretaker?

A If the circumstances of a specific case do come that you can say without a doubt that child abuse has occurred, you could, then, I guess, feel comfortable signing this form.

Q Okay. I'm going to use the converse; okay? If you can say without a doubt that it did not occur, you could safely discharge him home; right?

A Again with the negatives, what?

Q Okay. If you can safely -- if you can say --

A Yes.

Q -- that unequivocally there was no child

Page 45

abuse, it is safe to discharge him?
A Yeah, I guess, yes.
Q It's the converse of what you said?
A Yes, yes.
Q You said "equivocally." If you said there was a child abuse, you could say it may not be safe to send him home?
A Yes.
Q But if you take the exact converse, if you can say unequivocally there was no child abuse, you can safely send him home; right?
A Yes.
Q Now, but Owen Carduff fell in between those two things?
A Yes. There was some elements of the workup that stated that there was concern for non-accidental trauma, but other elements of the workup of the evaluation which did not meet the criteria because they were negative and therefore, it could not be determined whether or whether not he had been the victim of child abuse.
Q Okay. And I think one of the things you said was the skeleton survey?
A Skeletal survey.
Q "Skeletal survey."

Page 46

A Right.
Q And the skeletal survey would have been where they do radiograph of both arms, both legs, and your core.
A Yes.
Q And your head?
A Yes, "and your head."
Q And they determine whether there's been any previous fractures or evidence of any kind of breaks or something that would indicate any kind of trauma; right?
A Yes.
Q Now, when you have abusive head trauma, would you agree with me that many times you do not see any other signs of symptomology on a skeletal exam?
MR. TODD: Objection.
THE WITNESS: It depends on the specifics of the case.
BY MR. HOOD:
Q It depends on the actual case itself?
A Yes.
Q And when you have someone who has an isolated incident of abusive head trauma, you may not see anything on a skeletal survey; right?

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A You may or may not.
Q Okay. And so in this particular case, because of the abusive head trauma -- excuse me.
In this case, because of the subdural hematomas, the skeletal survey may or may not help?
A May or -- it may or may not help, depending. You may also repeat it in two weeks to see if there were any injuries that were young and were fresh if you didn't see them on the first skeletal survey.
Q And -- and in doing that I know there's a huge, huge controversy over shaken-baby syndrome that is now called abusive head trauma.
A Yes.
Q And I know that -- there is a classic triad. I know there's a -- a -- you know, there are mimics that are written about in the literature. I know that they don't even use that nomenclature anymore --
A Sure.
Q -- in the medical field?
A Right.
Q It's now AHT --
A Right.
Q -- as opposed to SBS?

Page 48

A Right.
Q And when you have a situation and you've ruled everything out except for either accidental or non-accidental trauma, how do you ensure a baby is safe if you don't know that it's not non-accidental trauma?
A You put in place a safety plan and you report them to the Department of Social Services and you get law enforcement to involve -- to investigate if they can further get information to see if there is anything that corroborates for there to be accidental or non-accidental trauma.
Q Okay. And so when you get it to a point where you've ruled in or out everything except for accidental versus non-accidental trauma, then you work with DSS and law enforcement to determine whether it's one of the two; right?
A Or a combination of both or -- what -- or whatever.
Q Or a combination of the both --
A Yeah, whatever.
Q -- because you can have accidental trauma and non-accidental trauma?
A Yes, yes.
Q Okay. And -- and so in that case, you would be

DATE	TIME	RECORD PROGRESS OF CASE, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, AND INSTRUCTIONS TO PATIENT
12/7/09		NSUG
	1000	Family reports hx [illegible]
		Chronic reflux [illegible]
		Parents have noticed [illegible]
		uncertain if present from birth.
		Happy, active. MAE.
		[illegible] position [illegible]
		HC - 45.5 cm
		- will obtain HC graph from Peds [illegible]
		Dr. Baxter (803-980-7337)
		left message
		[illegible signature]
		BMcGanahan 1-2-10 1115
12-7-09		Neurosurg
	1845	Alert. Doing well overall. Repeat CT shows stable extra-axial collections, (R) denser than (L). OK to discharge under supervision — will need to see in f/u 2-3 weeks. Should be instructed prior to disch re. s/s of ↑ICP.
		McGanahan

ABBREVIATIONS

USE	DO NOT USE
Units	u or U
International units	IU
X mg (Never use a trailing zero)	X.0 mg
0.X mg (Always use a leading zero)	.X mg
daily	QD
every other day	QOD
Morphine	MS or MSO_4
Magnesium Sulfate	$MgSO_4$

Carolinas HealthCare System
PROGRESS RECORD
(3/07)

09339-00393
C000545-02-19
C[redacted] OWEN [redacted]
ATT PHY: 66247 CHIPS,TEAM A
12/05/09 DOB: [redacted]

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
) SIXTEENTH JUDICIAL CIRCUIT
COUNTY OF YORK)
)
) CASE NO.: 2011-CP-46-4508
)
Elizabeth Hope Rainey, as the Appointed) **MOTION AND ORDER INFORMATION**
Guardian Ad Litem to Owen C[redacted] a minor
Plaintiff,) **FORM AND COVERSHEET**
vs.)
)
Charlotte-Mecklenburg Hospital Authority)
d/b/a Carolinas Medical Center, South
Carolina Department of Social Services, and
Bruce Bryant, as the Constitutional Office of
the Sheriff of York County, the York County
Sheriff's Department, and York County,
Defendant.)

FILED-RECEIVED
2013 MAY 22 AM 11:50
DAVID HAMILTON
C.C.C.P. & G.S.
YORK COUNTY, SC

Plaintiff's Attorney:	Defendant's Attorney:
S. Randall Hood, Bar No. 65360	See attached, Bar No. _____
Address:	Address:
1539 Health Care Drive, Rock Hill, SC 29732	_____
Phone: 803-327-7800Fax 803-328-5656	Phone: _____ Fax_____
E-mail: rhood@mcgowanhood.comOther: _____	E-mail: _____Other: _____

☒ **MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III)**
☐ **FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III)**
☐ **PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)**

SECTION I: Hearing Information

Nature of Motion: Plaintiff's Motion for Reconsideration and Memorandum of Law in Support of Motion

Estimated Time Needed: _____ Court Reporter Needed: ☒ YES/☐ NO

SECTION II: Motion/Order Type

☒ Written motion attached
☐ Form Motion/Order

I hereby move for relief or action by the court as set forth in the attached proposed order.

_____ 5/22/2013
Signature of Attorney for ☒ Plaintiff/☐ Defendant Date submitted

SECTION III: Motion Fee

☒ PAID – AMOUNT: $ 25.00
☐ EXEMPT: (check reason)
☐ Rule to Show Cause in Child or Spousal Support
☐ Domestic Abuse or Abuse and Neglect
☐ Indigent Status ☐ State Agency v. Indigent Party
☐ Sexually Violent Predator Act ☐ Post-Conviction Relief
☐ Motion for Stay in Bankruptcy
☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRCP)
☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions
Name of Court Reporter: _____
☐ Other: _____

JUDGE'S SECTION	
☐ Motion Fee to be paid upon filing of the attached order.	JUDGE CODE _____
☐ Other: _____	Date: _____

CLERK'S VERIFICATION

Collected by: Leigh Ann Alexander Date Filed: 5-22-13

☑ MOTION FEE COLLECTED: $ 25.00

☐ CONTESTED – AMOUNT DUE: $ _____

SCCA 233 (11/2003)